GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE INSPECTOR GENERAL

AUDIT OF THE MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES PROGRAM

CHARLES C. MADDOX, ESQ.
INSPECTOR GENERAL

Audit Report No. OIG No. 23-99JA **October 26, 2000**

GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE INSPECTOR GENERAL

Inspector General

October 26, 2000

Carolyn N. Graham
Deputy Mayor for Children,
Youth and Families
441 4th Street, N.W., Suite 960N
Washington, D.C. 20001

Ivan C.A. Walks, M.D.
Director
Department of Health
825 North Capitol Street, N.E., Suite 4400
Washington D.C. 20002

Dear Ms. Graham and Dr. Walks:

Enclosed is the final report (OIG No. 23-99JA) summarizing the results of our audit of the Mental Retardation and Developmental Disabilities Program (MRDDP).

Specifically, our audit revealed that the Department of Human Services (DHS) and/or the Department of Health (DOH) needed to:

- Develop and implement a strategic plan and establish a performance measurement system for the Mental Retardation and Developmental Disabilities Administration;
- Take appropriate action to collect $6.8 million due to the District from eight group home providers;
- Improve procedures for criminal history checks and training of direct care staff;
- Establish formal procedures to properly account for and safeguard MRDDP client bank accounts;
- Update provider agreements, ensure that they are renewed in a timely manner, and establish formal procedures for reviewing provider agreements for legal sufficiency;
- Monitor group home providers to ensure compliance with all contract provisions, laws, rules, and regulations;
- Establish formal procedures for processing payments to group home providers;
- File tax returns in a timely manner for all MRDDP clients that are due a tax refund; and
- Implement controls over MRDDP client work programs to ensure that clients are not exploited and are engaged in meaningful care or training.

Factors causing these conditions include insufficient policies and procedures, noncompliance with directives, internal control weaknesses, and a lack of management continuity. Accordingly, this report contains recommendations that, collectively, represent actions considered necessary to correct the noted conditions.

In order to facilitate the audit process we issued Management Alert Reports to DHS and DOH on filing tax returns for MRDDP clients, revising and updating provider agreements, and conducting criminal history checks of direct care workers.

The DHS and DOH comments (Exhibit 1) to a draft of this report are generally responsive to the intent of the recommendations. However, recommendation 3b remains unresolved. Therefore, DOH should reconsider its position on recommendation 3b to ensure that appropriate background checks, which include criminal history checks, are performed periodically to update employee background status.

Generally audit recommendations should be resolved within 6 months of the date of the final report. Accordingly, we will continue to work with DOH to reach a final agreement on recommendation 3b. DOH, by November 27, 2000, should readdress recommendation 3b and provide its response to our office.

We appreciate the cooperation and courtesies extended to our staff by DOH and DHS personnel during the audit. Further, we commend the DOH and DHS management and staff for facilitating the audit process and recognizing the need to make systemic improvements.

If you have questions about this report please call me or William J. DiVello, Assistant Inspector General for Audits, at (202) 727-2540.

Sincerely,

Charles C. Maddox, Esq.
Inspector General

Enclosure

DISTRIBUTION:

The Honorable Anthony A. Williams, Mayor, District of Columbia (1 copy)
Dr. Abdusalam Omer, Chief of Staff (1 copy)
Mr. John A. Koskinen, City Administrator/Deputy Mayor for Operations (1 copy)
Ms. Peggy Armstrong, Mayor's Press Secretary (1 copy)
Ms. Lydia Sermons, Director, Office of Communications (1 copy)
The Honorable Alice M. Rivlin, Chairman, DCFRA (1 copy)
Mr. Francis Smith, Executive Director, DCFRA (1 copy)
Mr. Russell Smith, Chief of Staff, DCFRA (5 copies)
The Honorable Linda W. Cropp, Chairman,
Council of the District of Columbia (1 copy)
Ms. Phyllis Jones, Secretary to the Council (13 copies)
The Honorable Kathleen Patterson, Chairperson, Committee on Government Operations, Council of the District of Columbia (1 copy)
Dr. Natwar M. Gandhi, Chief Financial Officer (4 copies)
Ms. Deborah K. Nichols, D.C. Auditor (1 copy)
Mr. Jacques Abadie, Interim Chief Procurement Officer,
Office of Contracting and Procurement (1 copy)
Mr. Jeffrey C. Steinhoff, Assistant Comptroller General, GAO (1 copy)
Ms. Gloria Jarmon, Director, Civil Audits, HEHS, GAO (1 copy)
The Honorable Eleanor Holmes Norton, D.C. Delegate, House of Representatives (1 copy)
Mr. Jon Bouker, Office of the Honorable Eleanor Holmes Norton (1 copy)
The Honorable Ernest J. Istook, Jr., Chairman, House Committee on Appropriations, Subcommittee on D.C. (1 copy)
Mr. John Albaugh, Office of the Honorable Ernest J. Istook, Jr. (1 copy)
Mr. Migo Miconi, Clerk, House Subcommittee on D.C. Appropriations (1 copy)
The Honorable James P. Moran, Jr., House of Representatives Committee on Appropriations
Mr. Tim Aiken, Office of the Honorable James Moran, (1 copy)
The Honorable Tom Davis, Chairman, House Committee on Government Reform and Oversight, Subcommittee on D.C. (1 copy)
Ms. Melissa Wojciak, Staff Director, House Committee on Government Reform and Oversight, Subcommittee on D.C. (1 copy)
Mr. Robert Dix, Clerk, House Committee on Government Reform and Oversight, Subcommittee on D.C. (1 copy)
The Honorable George V. Voinovich, Chairman, Senate Subcommittee on Government Oversight (1 copy)
Mr. Peter M. Rowan, Legislative Clerk, Senate Subcommittee on Government Oversight (1 copy)
The Honorable Kay Bailey Hutchison, Chairman, Senate Appropriations, D.C. Subcommittee (1 copy)
Ms. Mary Beth Nethercutt, Clerk, Senate Committee on Appropriations, D.C. Subcommittee (1 copy)

TABLE OF CONTENTS

TABLE OF CONTENTS (CON'T)

E X E C U T I V E

D I G E S T

EXECUTIVE DIGEST

OVERVIEW

This report summarizes the Office of the Inspector General's (OIG) audit of the Mental Retardation and Developmental Disabilities Program (MRDDP). The Department of Human Services (DHS), Mental Retardation and Developmental Disabilities Administration (MRDDA), and the Department of Health (DOH) are primarily responsible for administering the program. The audit was conducted, in part, because of concerns raised regarding allegations of abuse, neglect, and mistreatment of MRDDP clients (clients) placed in community residential facilities.

CONCLUSIONS

This report contains 10 findings that include the details supporting the conditions we observed and documented. We believe improvements by DHS and DOH are needed to ensure that: (1) a strategic plan and a performance measurement system is developed for MRDDA; (2) action is taken to collect $6.8 million due to the District from eight group home providers; (3) procedures for background investigations and training of direct care staff are improved; (4) formal procedures are established for accounting for client bank accounts and for processing payments to group home providers; (5) formal procedures are established for a legal sufficiency review of provider agreements; providers comply with all contract provisions laws, rules, and regulations; and (6) formal procedures are established for client work programs.

CORRECTIVE ACTIONS

We directed recommendations to the Directors of the DOH and the DHS that we believe are necessary to correct the deficiencies noted in the findings included in this report. The recommendations, in part, center on:

- Identifying measurable goals and objectives to commit management to specific improvements;
- Collecting overpayments due the District;
- Proposing legislation that require evaluation of a perspective employees' arrest records;
- Identifying courses requiring competency-based training;
- Evaluating procedures for client work program;
- Establishing formal procedures for accounting for client bank accounts and for processing payments to group home providers;
- Complying with laws, rules and regulations, and agency directives; and

EXECUTIVE DIGEST

- Establishing formal procedures for reviewing provider agreements for legal sufficiency.

On October 20, 2000, DHS and DOH provided a formal response to the recommendations in the draft report. Management generally concurred with the report and provided a listing of actions taken or planned to address each recommendation. The complete response is included as Exhibit 1.

I N T R O D U C T I O N

INTRODUCTION

BACKGROUND

The mission of DOH is to assure a safe and healthy environment for the citizens of the District by working with all partners in strategic alliances to: (1) design public health systems based on community involvement and customer needs; (2) conduct continuous monitoring of health status to include investigation of potential threats and intervention when needed; (3) provide leadership in public health policy development; (4) assure access to high quality health services; (5) foster and promote health education and disease prevention; and (6) maximize the effectiveness of all resources.

The mission of DHS is to provide comprehensive quality human services to enhance life in the District of Columbia. DHS achieves its mission through the work of the Commission on Social Services, which administers the District's social services programs. The Commission on Social Services is comprised of seven offices, each of which is a separate control center within the budget. These seven offices are the Commissioner of Social Services; Office of Early Childhood Development, Income Maintenance, Youth Services Administration, Family Services Administration, Rehabilitation Services Administration, and MRDDA.

The mission of MRDDA is to plan, coordinate, develop, and administer a network of services that support persons with mental retardation or other developmental disabilities. MRDDA operates under a court order, the Pratt Consent Decree issued in 1978. This court order makes specific requirements pertaining to Individual Habilitation Programs (IHP) and other case management issues, requires a system of monitoring MRDDA community-based residential programs, and specifies the time frame for payments to vendors.

Community Based Residential Facilities. We included in our review two types of community based residential facilities for mentally retarded persons: Intermediate Care Facilities for the Mentally Retarded (ICFMR) which are funded by Medicaid (federal) funds and Community Residential Facilities for the mentally retarded (CRF) funded by appropriated (local) funds. There are 12 CRF providers that service approximately 165 clients on a contractual basis with the DHS. There are 22 ICFMRs that provide services to approximately 752 clients pursuant to provider agreements entered into with the Medical Assistance Administration (MAA). MAA is an administration within the DOH and is charged with administering the Medicaid program in the District of Columbia.

Client Living Conditions. We conducted site visits at 10 group homes to observe and evaluate the everyday living environment of clients. We noted, for the most part, that group home providers maintained a clean and comfortable living environment for the clients as shown in the following illustrations:

INTRODUCTION

Below: Two-story Intermediate Care Facility (front) for 8 clients located in Southeast D.C.

Below: This picture illustrates the same facility (back) backyard with porch and chairs, wooden picnic tables, benches, and a grill.

INTRODUCTION

Below: Standard client bedrooms are generally equipped with modern furniture that includes beds with clean linen and blankets, dressers, drawers, closets, window blinds, curtains, and fans.

Below: A typical handicapped-equipped transportation van has the capability of transporting at least 8 clients to and from programs and other needed services.

INTRODUCTION

OBJECTIVES

The audit objectives were to evaluate the adequacy of contract planning, management, and administrative practices relative to services provided to the MRDDP. These objectives were applied to the areas of contracts, core competencies of health care workers, processing of payments to group home providers, delivery of services to MRDDP clients, and MRDDP client bank accounts.

SCOPE AND METHODOLOGY

The audit scope primarily covered transactions from fiscal year (FY) 1998 through the second quarter of FY 2000. To accomplish our objectives, we reviewed supporting documentation for approximately $6 million in monthly payments issued to 3 providers operating 12 group homes. We also examined 55 IHPs and related records at 10 group homes and 400 expenditures from client bank accounts totaling $79,000. In addition, we reviewed personnel and training records for more than 200 direct care staff employed by 10 group home providers.

We held discussions with District officials and with officials and direct care staff at the group homes; in addition, we made general observations and inspections at those sites. Meetings were held with a private contractor who processed Medicaid payments for the District of Columbia. We also contacted officials in three states to obtain information on procedures used to conduct background checks and for training of direct care staff for employees who provide health care related services for mentally retarded persons.

We were part of a special task force headed by the United States Attorney (USA) for the District of Columbia. In this regard, we coordinated our efforts with officials from the USA's office, the Federal Bureau of Investigation, and the Social Security Administration. Additionally, we coordinated our efforts with the Internal Revenue Service, the District’s Office of Tax and Revenue, and the U.S. Department of Health and Human Services OIG.

We conducted our audit in accordance with generally accepted auditing standards and included such tests as we considered necessary under the circumstances.

F I N D I N G S

&

R E C O M M E N D A T I O N S

FINDINGS AND RECOMMENDATIONS

FINDING 1: STRATEGIC PLANNING AND PERFORMANCE MEASUREMENT

SYNOPSIS

MRDDA did not implement a strategic plan and did not establish a performance measurement system. MRDDA drafted a "Five Year Strategic Plan" (the Strategic Plan) in fiscal year 1998. This plan was developed in recognition of the need for a change from the traditional system-driven approach to a persons-centered approach of providing services to mentally retarded persons. However, MRDDA did not implement this Strategic Plan. Without such a plan, the District can not be assured that the millions allocated and spent will achieve desirable and measurable results. MRDDA also did not establish a performance measurement system that would show how funds expended for clients actually benefited the clients and how results achieved compared to the results anticipated. Such a system would provide additional indicators that the clients' health, safety, and well being were or were not in jeopardy.

Consequently, MRDDA could not definitively measure or evaluate program progress, efficiency, and effectiveness, although it spent more than $438 million from fiscal year 1995 through 1999. We attribute the lack of a strategic plan and performance measurement system to continued turnover of executive managers. Over the last 5 years, MRDDA had at least 5 different top administrators, 3 within the last 18 months. During the time of our audit fieldwork, MRDDA's two top executives changed.

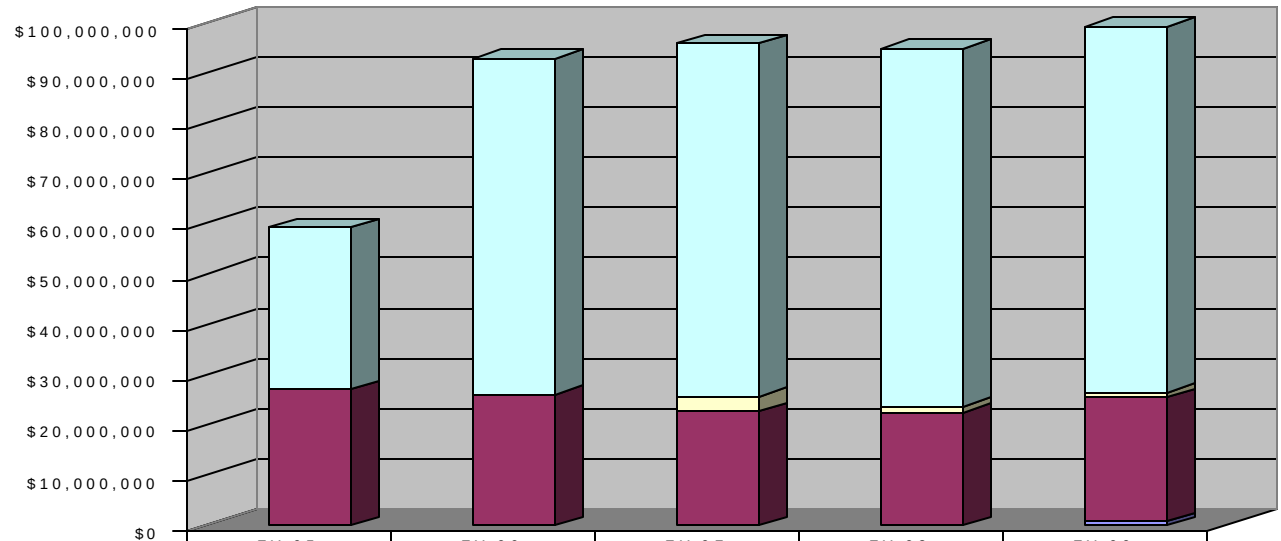
AUDIT RESULTS

Strategic Plan. MRDDA drafted a Strategic Plan in fiscal year 1998 but did not implement it. The basic objectives of the plan were to provide MRDDA with a strategy to become more reliant on the private sector, community, and families for provisions of services and support and less dependent on government to achieve its mission. A strategic plan helps ensure that the program meets measurable goals and objectives by committing management to specific improvements and also helps to ensure that District and federal Medicaid funds are spent in a prudent and economical manner.

During the 5-year period from fiscal year 1995 through 1999, MRDDA program expenditures totaled more than $438 million. MRDDA spent the majority of funds for services provided by ICFMRs and CRFs as shown in the graph that follows.

FINDINGS AND RECOMMENDATIONS

MRDDA Expenditures for Intermediate Care and Community Residential Facilities



	FY 95	FY 96	FY 97	FY 98	FY 99
Medicaid	$32,280,997	$66,988,116	$70,266,000	$71,313,823	$72,813,000
Other Federal	$0	$0	$2,895,478	$1,154,247	$900,949
Appropriated	$26,965,997	$25,840,560	$22,643,069	$22,376,077	$24,657,723
Other	$0	$0	$0	$0	$750,000
Totals	**$59,246,994**	**$92,828,676**	**$95,804,547**	**$94,844,147**	**$98,371,672**

Note: DOH provided Medicaid figures. DHS provided figures for Appropriated, Other, and Other Federal. We did not test these amounts for accuracy.

The preceding graph does not include the costs associated with client day programs, transportation, rehabilitation, and other services. In fiscal year 1999, the total program expenditures for the care and wellbeing of clients exceeded $130 million. However, MRDDA had not implemented a strategic plan to determine goals and outcomes and a clearly defined method of achieving its mission. Consequently, there is no assurance that funds were spent (or will be spent) in a prudent and economical manner.

MRDDA officials disclosed that a 5-year plan had been developed but not implemented. We obtained and reviewed the plan, which in our opinion was adequate. The plan listed the following six goals as priorities that need to be accomplished:

1. Effect system change to enhance service delivery and make it customer driven,

2. Enhance federal and other revenue maximization efforts,

3. Establish a communications network,

FINDINGS AND RECOMMENDATIONS

4. Implement an automated management information system,

5. Implement a quality assurance program, and

6. Comply with legal mandates.

Performance Measurement System. MRDDA had not established a performance measurement system. Such a system would improve the protection, services, and support for clients because it would show how funds expended for clients actually benefited the clients and how results achieved compared to the results anticipated. MRDDA officials informed us that an employee performance measurement system (work standards) had been drafted but not formally approved.

Furthermore, we obtained from the Office of the Mayor the latest reported status of agency performance measures for the Mayor's Scorecard, which included specific measures for MRDDA. We noted that MRDDA discontinued its attempts to measure progress and to achieve the goals established, noting that the goals were unrealistic. This discontinuation exemplifies the ineffectiveness of program management and the urgent need to develop and implement an operational strategy to achieve program goals.

CONCLUSION

A strategic plan is needed as well as a performance measurement system to improve management of the MRDDA. However, the plan and a performance measurement system would be of little value should top management continue to change unless subsequent administrators and other executives "buy in" to the plan.

RECOMMENDATION 1

We recommend that the Director of DHS, implement a strategic plan for MRDDA -- regardless of management turnover -- that incorporates a performance measurement system to help ensure that measurable goals and objectives are met and to commit management to specific improvements.

DHS RESPONSE

DHS stated in its response that since January 2000, significant changes have been implemented to bring stability, efficiency and effectiveness to the MRDD system. This process has been aided by the establishment of an Inter-Agency Task Force that is responsible for implementing those tasks and procedures that facilitate the restructuring. Strategic goals include development of policies and procedures for MRDDA and other agencies in the MRDD system; outsourcing case management services for MRDDA; implementation of a plan to exit the Evans Consent Decree; conducting assessments on customers at-risk for critical health outcomes;

FINDINGS AND RECOMMENDATIONS

establishment of a MRDD Fatality Review Committee; and development and submission of a revised Medicaid waiver application. Time frames and performance measures have been developed for each of these goals.

OIG COMMENT

The actions planned and taken by DHS should correct the conditions noted.

FINDINGS AND RECOMMENDATIONS

FINDING 2: RECOVERY OF DISALLOWED COSTS

SYNOPSIS

MAA did not recover $6.8 million in overpayments to 8 group home providers during the 6 year period, from fiscal year 1991 to 1996. This amount has been outstanding since 1997. As a result of not recovering this amount, the District has lost at least $300,000 in interest revenue. We believe a high risk exists that the District will not fully recover amounts owed due to the age of the receivables. MAA's audits of annual cost reports of group home providers showed that providers were paid for disallowed costs. MAA did not perform audits of group home providers' annual cost reports for years 1991 through 1996 until 1996. Consequently, these overpayments were not identified until fiscal year 1996, and actions taken to recover the disallowed costs did not begin until fiscal year 1997.

MAA's action to recover the overpayments was not in compliance with federal regulations and was not in the best interest of the District government. MAA informed us that 41 audits of group home providers' annual cost reports, for fiscal year 1996 were not completed. This would suggest that more overpayments may have occurred and that the District has incurred more costs than it should. We believe that MAA's audit reports will likely identify an additional $3 million in overpayments once these audits are completed.

AUDIT RESULTS

Overpayments to Group Home Providers. Eight group home providers owed the District approximately $6.8 million as of August 2000. Audits of those provider's annual cost reports disclosed disallowed costs that were billed to and paid for by the District government. The disallowed costs represent overpayments that have been outstanding (uncollected) since 1997. MAA's inability to collect the outstanding amount has resulted in a loss of interest revenue for the District in the amount of $300,000. A schedule of the amounts due from the providers is shown as follows:

Provider	Amount Due
A	$ 35,141
B	42,784
C	289,082
D	469,629
E	621,099
F	1,203,688
G	1,747,267
H.	2,454,670
Total	**$ 6,863,360**

FINDINGS AND RECOMMENDATIONS

Suspension of Payments. The District may not be able to collect the entire amount. We determined that MAA's decision to collect amounts due from the group home providers on a prorated basis (a deduction of 20 percent of the providers' regular monthly payment) was not in compliance with existing federal regulations and is the principal reason why the amounts still remain uncollected. Pursuant to 42 CFR § 405.371, MAA is authorized to suspend payments to group home providers after it has been determined that an overpayment has been made. Additionally, 42 CFR § 405.372, requires that a suspension of payments be limited to 180 days, starting with the date of the suspension.

CONCLUSION

MAA elected to recover overpayments from the group home providers, on a pro rated basis, by deducting a portion of the providers' regular monthly payment. However, this method can result in repayments extending for an undetermined amount of time. We are perplexed by this rationale considering that costs billed by group home providers are audited annually and can result in more disallowed costs. Thus, the method used by MAA to recover overpayments can result in the total amount of an overpayment increasing rather than decreasing. Recovery of an overpayment must be evaluated on a case by case basis, depending upon the amount of the overpayment due to the District and the amount deducted from the providers monthly payment.

RECOMMENDATION 2

We recommend that the Director of DOH reevaluate the current method used to recover overpayments from group home providers and take sufficient measures, in compliance with federal regulations, to collect outstanding amounts due to the District.

DOH RESPONSE

In its response, DOH stated that a 20 percent monthly recoupment percentage is generally the standard percentage used for this program. It is not clear whether or not the District could legally accelerate the rate of recoupment for the providers who were overpaid by $6.8M since these providers and the District have already agreed on the repayment plan. In any event, the District of Columbia would be faced with an impossible task of trying to find homes for its MRDDA customers should any of the group homes close because of financial difficulties. Therefore, when MAA reviews the overall situation it seeks to recoup an amount that would allow recovery of the overpayment to the provider but permit the facilities to remain in operation. DOH, however, will continue to work with the providers with regard to any future overpayments to determine whether the rate of recovery can be set at a higher monthly rate.

FINDINGS AND RECOMMENDATIONS

OIG COMMENT

The action planned by DOH should correct the conditions noted. However, we are requesting that DOH provide our office documentation to support the rationale for using a 20 percent monthly recoupment rate.

FINDINGS AND RECOMMENDATIONS

FINDING 3: EMPLOYMENT OF DIRECT CARE WORKERS

SYNOPSIS

Direct care workers employed by operators of group homes for the mentally retarded have histories of criminal convictions and arrests. We initiated background checks on 128 workers, which revealed that 26 workers (20 percent) had records of one or more arrests. Of those workers, 17 had been arrested many times and 11 had been convicted at least once. Many arrests occurred within the last 5 years. Direct care workers with histories of criminal convictions and arrests were hired or allowed to continue to work for group home providers because providers did not always initiate required background investigations. In addition, existing regulations did not require periodic reinvestigations after hiring or require persons arrested or convicted of serious crimes to report the matter to the provider. Existing regulations also precluded only those convicted of certain crimes from employment, not those arrested for or convicted of other serious matters. Consequently, the clients' safety and financial interest may have been exposed to unnecessary risk.

AUDIT RESULTS

Criminal History Checks. We initiated background checks on 128 workers, which revealed that 26 individuals (20 percent) had one or more records of arrest. We performed criminal history checks using data obtained from the Federal Bureau of Investigation's National Crime Information Center (NCIC). Inasmuch as we do not have access to the fingerprints of the individuals in question, we did not conduct further checks to make certain that these individuals were in fact the same persons. However, we did check the court records for the municipality where these individuals were arrested and did confirm their innocent/guilt status as reported in NCIC to the extent possible. We do not know at this time why the providers still proceeded to hire these individuals. The manner by which providers conducted background checks could account for the reasons why these employees were still hired.

The following examples illustrate the conditions we found:

- One worker hired on December 2, 1999, used 19 aliases and had a history of arrests and convictions since 1971. The group home provider's records indicated that a criminal history check was completed March 22, 2000, yet this individual was still employed by the group home provider. An examination of the arrest record indicates that charges included, but were not limited to, carrying a pistol without a license, shoplifting, possession with intent to distribute heroin and cocaine and credit card forgery. The last arrest of record occurred in February 1998, when the individual was charged with possession of cocaine and was later convicted on August 28, 1998. However, because there was no specific drug possession or distribution prohibition in federal regulations governing the employment of direct care workers in ICFMRs, this

individual was able to obtain employment. By contrast, if the provider were operating a CRF under the group homes contracts currently in use, this individual would not have been employed.

- Another worker, who also had multiple arrests, was found guilty on March 22, 2000, for possessing controlled substances. However, a criminal background check was completed on March 28, 2000, and the worker started work on April 4, 2000, approximately two weeks after conviction. The individual was employed by an ICFMR provider, which could explain why the individual was hired. We do not know at this time how the group home provider conducted the background check, who conducted it and what information was used to evaluate whether a criminal history existed.

Existing Regulations. Existing federal Medicaid regulations and District of Columbia Municipal Regulations (DCMR) contain provisions prohibiting employment to persons with a history of certain criminal activity. However, these regulations may be inadequate and therefore should be reexamined. The regulations for criminal history checks for ICFMRs are contained in the Code of Federal Regulations (CFR). Pursuant to 42 CFR § 483.420 (Condition of participation – Client protections, paragraph (d)(1)(iii)), the intermediate care facility must prohibit the employment of individuals with a conviction or prior employment history of child or client abuse, neglect or mistreatment, but does not mention other types of criminal acts – many of which could expose clients and their financial interests to unnecessary risks.

The regulations for criminal history checks for CRFs are contained in DCMR Chapter 35 (Group Homes for Mentally Retarded Persons (GHMRP)) § 3509.9 which states that "Each GHMRP shall obtain employment references on each employee and no GHMRP shall employ an individual who has a history of the following: (a) Child or resident abuse or abuse of someone under his or her care and supervision; (b) Neglect; (c) Exploitation; or (d) Conviction for a sexual offense or violent crime." However, as is the case with the federal regulation, many other types of criminal activity are absent, and the provision limits the District's and the provider's authority to dismiss existing employees or preclude hiring employees arrested or convicted of other types of serious criminal activity.

The District's recent D.C. Law 12-238, "Unlicensed Personnel Criminal Background Check Act of 1998," effective April 20, 1999, brings consistency to background checks and identifies the type of illegal activities that would prohibit an applicant from obtaining employment as a direct care worker, irrespective of the type of facility being operated. DOH personnel informed us that the new law applies to all types of facilities rendering institutional health care services regardless of the funding source for the service.

However, while the law attempts to define further the type of offenses that would prevent a facility from employing a prospective applicant, in our opinion it may still be deficient. The law limits these offenses to convictions instead of arrests. Given the vulnerability of the

FINDINGS AND RECOMMENDATIONS

population of individuals that need attentive care, we believe that management may want to consider arrests as criteria for determining the suitability for employment as a direct care worker. An arrest for misdemeanor or felony charges may be, in itself, an indication of an undesirable character that should not be exposed to the mentally retarded. Also, in our opinion, the Director of the DOH should carefully craft the regulations implementing the procedures for facilities to comply with the requirement of criminal background checks for non-licensed workers in health-care facilities.

We realize that this is a sensitive matter that needs to be dealt with very carefully. The suitability of direct care workers could be compared to the suitability of candidates for police officer positions with the Metropolitan Police Department. Chapter 8, District Personnel Manual (DPM), § 873.11, enumerates the conditions that would prevent a candidate from being eligible as a police officer. These conditions are similar to the proscriptions contained in the April 20, 1999, law. However, § 873.12 further cites conditions that may cause a candidate to be ineligible. These conditions can be categorized as additional criteria for determining candidates' suitability for the position of police officer. For example, one provision that may cause a person to be ineligible is when that person has been arrested for or charged with a criminal offense that was nolle prossed (a formal entry on record where the government declares that it will not prosecute the case) or where the case was dismissed.

Therefore, we believe that in addition to the proscriptions contained in the current law, additional provisions of regulations for determining suitability of direct care workers may be appropriate. Whatever is eventually decided, we believe that guidance needs to be provided to group home providers so that they are in a position to fairly evaluate a candidate's underlying offense(s). Where there is/are no conviction(s), group home providers should be required to properly document the rationale for proceeding with employment of an applicant. As part of this process, court records need to be checked to obtain closure on the ultimate disposition of the arrest.

CONCLUSION

While group home providers' information shows that most applicants do have a criminal history check, there are indications that some applicants may not have undergone such a check. Also, in several cases, criminal background checks were conducted after the date of initial employment, thereby putting clients unnecessarily at risk depending on the results of the check. We also noted that once a criminal history is conducted, there is no requirement for periodic updates to ensure notification if employees are later arrested and/or convicted for prohibited criminal activity.

Furthermore, a draft of the Notice of Proposed Rulemaking for D.C. Law 12-238 waives certain convictions when they are more than ten (10) years old at the time of application for employment. Final rules for this law have yet to be completed.

FINDINGS AND RECOMMENDATIONS

RECOMMENDATION 3

We recommend that the Director of DHS in conjunction with the Director of DOH:

a. Consider recommending to the Council of the District of Columbia that D.C. Law 12-238, Unlicensed Personnel Criminal Background Check, be amended to include appropriate language that requires evaluation of an applicant's arrest record in determining his/her suitability as a direct care worker;

b. Draft the implementing regulation so as to require periodic updates of criminal history checks;

c. Take appropriate action against group home providers, as you deem necessary, with respect to the employment status of individuals who have criminal histories; and

d. Draft legislation that would require employees of providers to report arrests and convictions within 30 days and that providers take action appropriate for the circumstances.

DOH RESPONSE

Arrest Records of Applicants

The DOH has carefully considered the recommendation that the law and implementing regulations be amended to include language that requires an evaluation of an applicant's arrest record by a provider in determining his or her suitability as a direct care worker. The recommendation raises numerous public policy concerns. Because of concerns with the possibility of false accusations, racial profiling, the due process rights of an accused person (the person has not yet been convicted of a crime), and the U.S. EEOC Guidelines for the Uniform Selection of Employees which may actually prohibit reliance on arrests records in making certain employment decisions, the District may not be able to implement this specific recommendation. The District will reexamine this issue, after consultation with the U.S. Attorney, Office of Corporation Counsel, the D.C. Human Rights Office and the U.S. Equal Employment Opportunity Commission (EEOC), after the current regulations have been in effect for a sufficient period of time to assess the legality of and need, if any, for any further amendments.

Periodic Updates of Background Checks

The DOH has also carefully considered the recommendation that the regulations be drafted to include a requirement that health-care facilities obtain updated criminal background checks on each unlicensed employee or contract worker at certain specified intervals. Our research indicates that, of the states that have enacted criminal background check requirements,

FINDINGS AND RECOMMENDATIONS

only 12.5 percent have enacted periodic update requirements, and we note that neither Maryland nor Virginia require periodic updates. We do not believe that it would be practical or cost-effective to impose this requirement at this time; due to the high rate of staff turnover in this field. We conclude that it is more likely that a direct care worker will seek employment in a different facility, and therefore be required to undergo a new initial check, than that he or she will remain employed by a facility long enough to trigger a periodic update.

OIG COMMENT

DOH's responses for 3a, 3c, and 3d meet the intent of the recommendations. However, recommendation 3b remains unresolved. DOH should reconsider its position on recommendation 3b to ensure that appropriate background checks, which include criminal history checks, are performed periodically to update employee background status.

FINDINGS AND RECOMMENDATIONS

FINDING 4: DIRECT CARE STAFF TRAINING

SYNOPSIS

The audit disclosed that some of the direct care staff employed by group home providers had not completed required training in accordance with District and federal regulations. As a result, the protection, safety, and care of the clients may be jeopardized. This condition exists because DOH and DHS did not establish formal guidelines and procedures to ensure that direct care staff meet or exceed minimum training requirements and to ensure consistency in the type and content of training, method of instruction, and hours of training required.

We also found that group homes providers of CRFs were inconsistent in the implementation of orientation training requirements and did not relate training courses offered to direct care staff, to the specific requirements contained in the DCMR. For example, none of the providers offered training in assistive technologies, habilitation implementation, or lifesaving courses such as the Heimlich maneuver or disaster planning, which are required by District regulations. Consequently, we were unable to determine if the training offered by group home providers of CRFs met the intent of the DCMR.

Furthermore, we could not assess training overall because most group home providers did not maintain automated training records or did not properly record or maintain a record of training accomplishments in all of the employee personnel files.

AUDIT RESULTS

Direct care staff play an essential role in ensuring the health and safety of clients. However, we found that the District lacked written guidelines and procedures to identify the type of training or core competencies required for the direct care staff. Guidance was also lacking that would show the required timeframes for training (prior to providing direct care or within a certain time frame), the frequency of refresher or reinforcement training, and the length and composition of courses required.

Existing Regulations. Training requirements for direct care staff employed by group home providers of CRFs, are contained in the DCMR, Title 22 § 3510. The regulations require training for direct care staff in about 30 different areas. Some of theses areas include: definition and causes of mental retardation, associated health implications, frequently used medications, history of care of individuals with mental retardation daily living skills, human development, infection control for staff and residents, emergency procedures including, first aid, and cardiopulmonary resuscitation (CPR).

FINDINGS AND RECOMMENDATIONS

By contrast, the regulations for training of direct care staff employed by group home providers of ICFMRs are ambiguous and do not suggest which courses direct care staff of ICFMRs should take. Pursuant to 42 CFR § 483.430 (C) (4) (e), "[t]he facility must provide each employee with initial and continuing training that enables that employee to perform his or her duties effectively, efficiently, and competently. For employees who work with clients, training must focus on skills and competencies directed toward clients' developmental, behavioral, and health needs."

In our opinion, these provisions do not offer ICFMR group home providers with sufficient guidance covering the content or substance of initial training and do not require any time limitations or requirements on completion of initial training. We also noted that the CFR does not require direct care workers employed by group home providers of ICFMRs to obtain any certifications in order to provide services to mentally retarded persons.

Orientation Programs. Group home providers of CRFs inconsistently implemented the orientation program requirements contained in DCMR, Title 22, § 3510.1, which states that "[e]ach employee who has no previous experience working with individuals with mental retardation shall be required to successfully complete orientation training appropriate to the needs of the residents in the GHMRP." Our comparison of employee hire dates and orientation attendance dates showed inconsistency as to when group home providers allowed direct care staff to provide care to clients. We noted that some direct care staff provided care to clients prior to completing any orientation courses, others after completion of the entire course, and some within a certain time frame.

Our comparison of employee hire dates and orientation attendance dates showed that some group home providers allowed direct care staff to provide care to clients prior to completing any orientation courses, thereby jeopardizing the clients' health and safety. Other group home providers required direct care staff to only initiate orientation training prior to providing care to clients, others within a certain time length, and others after completion of the entire course.

Certification requirements. DCMR, Title 22 § 3510.6 requires, when available, that each employee completes the class curriculum or takes and satisfactorily completes a competency evaluation of the certification training. We found that certification programs or competency requirements had not been implemented in accordance with the requirements of the DCMR, although certification programs had been established and were available for courses such as first aid, CPR, and food handlers. Also, we noted a disparity in certification requirements among group home providers. Some group home providers required direct care staff to obtain certifications in first aid, CPR, and food handler classes, while other providers did not. One group home provider required the certifications but the certifications for those individuals lapsed because refresher training was not obtained.

FINDINGS AND RECOMMENDATIONS

Inconsistency of Providers Training Policies and Procedures. As part of our audit, we reviewed training policies and procedures developed by the group home providers, as well as training programs, lesson plans, and class presentation materials used. We found that not all of the group home providers had developed written policies and procedures for training and none of the providers had procedures for monitoring training. Also, we found no indication that group home providers had assessed the training needs of its employees or developed corresponding training guidelines and schedules that demonstrated how it planned to meet the training needs of its staff.

Furthermore, the course content was developed without input or approval from DOH or MRDDA to ensure uniformity in course content. We also found a disparity in the composition and duration of class sessions among courses offered by group home providers. Additionally, there was no indication that DOH staff or MRDDA caseworkers visited, evaluated, or had knowledge of the course content or subject matter covered in the courses offered by group home providers.

Competency Based Training. Policies and procedures had not addressed the need for identifying competency-based training or identifying specific courses that require competency based training. Because of the absence of training guidance, we requested and received training policies and procedures from three other state agencies.

The state agencies provided us with literature that described the need for competency based training courses. The literature described competency-based training as a teaching method requiring class participants to demonstrate their knowledge of the courses being taught. Also, the literature described courses where normal pre and post testing would suffice to measure a person's competence and explained the need for competence based training in specific courses. An example of competency based training is CPR, where participants are required to demonstrate the use of CPR to indicate competency in administering CPR.

The literature, in addition to identifying the need for competency based training in specific subjects, also discussed when certain training courses should be given (phasing). Courses were identified where training was mandatory before a staff person began working directly with mentally retarded clients. The literature also identified courses where training could be provided over the first three months of employment and other training can be provided on an ongoing basis.

Individual Class Attendance/Training Documentation. Group home providers did not always maintain adequate attendance records needed to corroborate class attendance and course completion. District regulations required each training program's agenda and record of staff participation to be maintained and available for review by regulatory agencies and to be documented in each employee's personnel folder.

FINDINGS AND RECOMMENDATIONS

We reviewed training attendance records for over 200 direct care staff maintained by 10 group home providers to determine if direct care staff members had met all of the training requirements. We found group home providers had documented training and attendance using signatures on training attendance sheets and maintained the attendance records in three ring binders. However, although the group homes maintained training class attendance records, documentation was not always transferred or posted to the individual employee's personnel or training records. Because of the difficulty in reviewing volumes of individual class training sign in sheets and matching employees signatures with the corresponding training, we were unable to fully assess all the training provided to direct care staff.

Automated Training Records. We reviewed group home providers record systems, or databases, for tracking training requirements and attendance records of direct care staff. We found most group home providers did not maintain a database on training. Most group home providers maintained only manual original entry forms, which neither compiled nor assessed the information contained on the class attendance sheets. Only one group home provider had a formal record keeping system needed for tracking training requirements and attendance that would ensure training had been conducted and that certifications for training had been properly monitored and kept current. A training manager at one of the group homes informed us that an attempt to track training information proved futile because of the manner in which the records were maintained. We concluded that the group home providers or regulatory authorities could not, without great difficulty, readily assess the overall training provided to direct care workers.

Only one of the ten group home providers compiled training information and maintained a computerized database for training. Our review of those records, however, indicated that about 50 percent of the direct care staff did not have training in either CPR or first aid, two of the most basic and essential training requirements required for direct care staff.

RECOMMENDATION 4

We recommend that the Directors, DHS and DOH, coordinate activities to:

a. Provide group home providers with the guidance needed to uniformly implement the training requirements outlined in the DCMR. The guidance should include procedures to:

   1. require prior approval of training courses;

   2. identify courses requiring competency based training; and

   3. identify training courses that must be completed prior to allowing direct care staff to work with clients and the time frames other courses must be completed.

b. Require group home providers to develop and maintain record systems that would allow monitoring and tracking of individual staff training accomplishments.

FINDINGS AND RECOMMENDATIONS

c. Require group home providers to perform routine and periodic assessments of staff training to determine training needs.

DOH RESPONSE

An on-going training program for all staff working within the mental retardation and developmental disabilities services system will be developed and implemented. As part of its restructuring efforts, MRDDA will employ a Training Coordinator to interface with its employees and providers. The agency will establish general training guidelines that will provide guidance for determining the frequency of required refresher training and advanced training for provider staff. Guidelines will also include requirements for periodic assessments of staff training needs. Group home providers are to maintain training records, training attendance sign-in sheets, and training curriculum that they develop, to allow for tracking of individual staff training accomplishments.

OIG COMMENT

The action taken or planned by DHS should correct the conditions noted.

FINDINGS AND RECOMMENDATIONS

FINDING 5: CLIENT BANK ACCOUNTS

SYNOPSIS

The audit disclosed that clients' bank accounts were not properly accounted for or adequately safeguarded against loss. We found that group home providers did not always place client funds in interest bearing accounts, as required. Additionally, DHS delayed forwarding supplemental security income payments (SSI) to clients for as much as seven months. As a result, clients' bank accounts did not receive potential annual interest income, which could total as much as $158,000. DHS did not have written procedures or other controls to ensure that clients received merchandise purchased on their behalf or to ensure that group home providers accounted for these expenditures in a consistent and timely manner. Therefore, we could not ascertain whether the clients received all merchandise charged to their accounts.

AUDIT RESULTS

Clients were eligible for SSI and entitled to receive a monthly personal care allowance. The Social Security Administration (SSA) forwards monthly SSI checks for each eligible client to DHS, Payment and Collections Division (PCD). PCD is authorized to be the clients' representative payee and separates the funds into two categories: a cost of care allowance and a personal care allowance. The cost of care allowance offsets the costs incurred by the Medicaid system and/or the District of Columbia for the provision of services and support. The personal care allowance is posted by PCD to a client control account and later forwarded to the group home provider of the client.

PCD transfers clients' personal care allowances ($70 per month) on a quarterly basis to the respective group home providers. Group home providers, in turn, deposit these monies into the client's community bank account. Disbursements on behalf of clients are made and accounted for by group home providers from this account. Personal care allowances are monitored by MRDDA and reconciled in the clients' Individual Financial Plan.

Interest Bearing Accounts. Group home providers did not always place client funds in interest bearing accounts. Federal regulations (CFR 42, § 483.10) and District regulations (DCMR, Title 22, § 3407), require group home providers to establish and maintain a financial system that ensures full and separate accounting of each client's funds administered by the provider. Deposits of over $50 are required to be placed in interest bearing accounts, and any interest accrued must be credited to that account. Our review of 4 group home providers disclosed that one provider, who provided services for 38 clients in 5 homes, had not placed the clients' funds in interest bearing accounts. As a result, the clients did not receive interest income to which they were entitled. Depositing client funds into interest bearing accounts and properly managing those accounts takes on added importance because the annual interest income on those

accounts can exceed the equivalent of a full month's income for most clients. We calculated the average annual interest income to be approximately $157,500 ($90,000 + $67,500) for community account funds and burial account funds.

Community Account Funds. The only source of income for most clients is their monthly personal care allowance of $70. SSA limits each SSI eligible client's assets to $2,600 per year (at year's end) to retain their eligibility for monthly personal allowances. Assuming an average deposit of $2,000 (earning annual interest income at 6 percent), the client would earn approximately $120 annual interest income or significantly more than the client's personal care allowance for 1 month ($70). The potential annual interest on the approximately 750 client funds approaches $90,000.

The Burial Account Fund. MRDDA requires each client to pre-pay his or her own burial expenses (established with client funds) and has established an informal policy for each client to make periodic deposits until the balance reaches $1,500. Periodically the group home providers withdraw funds from the clients' account and forward those funds to DHS, which in turn deposits the funds in a non-interest bearing trust account. The maximum $1,500 balance for each client factored by an interest rate of 6 percent for each of the approximate 750 clients, equates to lost interest income of about $67,500 per year or approximately $90 per client.

Processing Delays. DHS delayed forwarding personal allowance payments to clients for as much as 7 months, which resulted in a loss of interest income. At the beginning of each month, the SSA forwards SSI checks for personal care allowances in the amount of $70 to PCD for clients. One of the most common complaints by group home providers was that PCD was consistently slow in forwarding personal allowance payments. Therefore, we reviewed payment procedures and found that PCD had not established written policies and procedures for processing payments for clients and did not forward personal allowance payments to clients in a timely manner.

Procedures Used For ICFMR Clients. As previously mentioned, the PCD did not forward the social security checks (and SSI checks) monthly upon receipt from the SSA. Instead, PCD accumulated the monthly checks and sporadically forwarded the checks to the group home providers for as much as 224 days after the monthly check was received by PCD. We identified delays that ranged from 145 days to 224 days, with an average delay of 190 days.

Procedures Used For CRF Clients. PCD deposited client funds directly to non-interest bearing trust accounts, where the funds remained until a MRDDA case manager requested that the funds be transferred to the clients' community accounts. The same analysis regarding delays was performed at a CRF group home provider with similar results. Although records were not complete, we determined the CRF checks were not forwarded on a quarterly basis.

For example, on August 15, 2000, we visited a CRF group home provider and noted a $70 client check, dated August 7, 2000, that was issued for the month of January 2000 (about 7

FINDINGS AND RECOMMENDATIONS

months late). We also noted checks for two clients dated August 1, 2000, issued by SSA covering the 5-month period February through June 2000 (from two to six months late). The client was not compensated for the amount of interest lost.

During discussions with an official of PCD, we were informed that the checks for personal care allowance and the cost of care allowance are normally submitted to group home providers on a quarterly basis, after receipt and approval of the requisition form submitted by the MRDDA caseworker. The official also stated that formal procedures for processing personal allowance payments were being drafted and in the process of being finalized. Additionally, the official stated that clients' personal and cost of care allowances (checks) will soon be processed by a private sector bank, rather than the D.C. Treasurer, which will decrease the amount of processing time.

Controls and Documentation for Merchandise Purchased. Formal procedures and other controls had not been established to ensure that clients received the merchandise purchased on their behalf. We reviewed over 400 client account transactions for 83 clients covering the last quarter of FY 1998 and all of FY 1999, totaling $78,813. These clients lived in 14 group homes maintained by 4 group home providers. We reviewed the clients' personal allowance to ensure that the funds were received and available for use by the client, properly accounted for, and safeguarded against theft or misuse.

We reviewed numerous store receipts, mainly for clothing purchases for clients, that did not adequately describe the items purchased. We noted many instances where cash register receipts provided by merchants contained no detail for the items purchased. Also, staff of the group home provider did not annotate the receipts to describe merchandise purchased or establish a system to ensure that the merchandise purchased was actually received by the client. For example, one cash register receipt listed 10 "ladies" items totaling $232.48. The payment was approved without any detail on the items purchased and no one independent of the purchasing transaction checked to determine whether the items were actually received by the client.

In another example, a cash register receipt identified 35 items simply as "sportswear" totaling $301. Again, the payment was approved without any detail on the items purchased, independent confirmation, or inventory to indicate that the client actually received the items purchased. For the most part, supporting receipts were available for client expenditures; however, there were numerous instances where insufficient detail was provided as to what was purchased. Therefore, we cannot assure that the clients actually received the merchandise purchased.

Allowable Costs. Neither MRDDA nor the group home providers had established specific procedures needed to ensure consistency in determining the types of expenses charged to client bank accounts. Because of the lack of policies and procedures, group home providers' inconsistently charged different costs to client bank accounts. The predominant type of expenses

charged to client accounts was clothing. However, we found group home providers' accounting for personal care items to be inconsistent. Two of the four providers charged their clients for monthly haircuts and toiletry articles, while the other two included these items as a part of their provider expenses. We were advised by staff at one group home that they provided these items rather than charging the clients' bank account because they were verbally informed to do so. Neither MRDDA nor the providers had established written procedures or standards for defining which costs were allowable and which costs were not allowable. Charging costs that are not allowable reduces funds available for clients.

Accounting Records. Only one of the four group home providers reviewed maintained a full and complete financial system detailing the expenditures from client bank accounts. Generally, the accounting records merely indicated monthly expense and income transactions and no subsidiary ledger accounts were maintained. Either hand-written ledger accounts were maintained or a summary of personal care revenues and related expenditures was prepared on a monthly basis. The other three providers did not maintain annual summaries or reports detailing the nature of the expenditures incurred during the year. Many expenses reviewed were inaccurately charged to client accounting records or were not processed in a timely manner. Most group home providers incorrectly charged clothing to client accounts, while supporting receipts showed expenses for personal items or entertainment.

One provider, with five clients residing at the same group home, charged each client $240 for vacation expenses on July 30, 1999. However, none of the five clients went on a vacation. Instead, the supporting documentation indicated that all five clients purchased clothes and incurred dinner expenses. All of the expenses were charged to clothing and not accounted for until more than 2 months later, October 11, 1999. Charging all expenses to clothing distorts the accuracy of the accounting records.

Other examples were also found for the untimely recording of expenses. On November 8, 1999, one group home provider charged each of eight clients at one house $500 for clothing. However, expense vouchers for all eight clients were not submitted until as late as February 2000, a 3 month lag between the time the clients accounts were charged and the time expenses were actually incurred. Another group home provider advanced funds from the provider's petty cash fund for expenses. When the petty cash fund was reimbursed, accounting detail on the type of expense was not maintained; instead, the accounting entry was simply to reimburse petty cash. Thus, in order to determine the type of expense incurred, auditors had to review petty cash receipts.

Bank Reconciliations. We found client accounts that were not reconciled in a timely manner. Monthly bank reconciliations were not performed in a timely fashion by two of the four group home providers. The records for one group home provider, reviewed by the auditors in July of 2000, had not been reconciled to the client's bank accounts since November 1999 – a period of over 8 months. This matter was brought to the attention of the provider by the auditor

FINDINGS AND RECOMMENDATIONS

and the accounts were immediately reconciled. Although the accounts balanced in this instance, the lack of monthly reconciliations can result in an undetected theft of funds.

RECOMMENDATION 5

We recommend that the Director, DHS, establish procedures to ensure that:

a. Group home providers place client funds in interest bearing accounts;

b. PCD forwards personal allowance payments to group home providers for deposit to client accounts in a timely manner;

c. Group home providers independently verify that items purchased for clients were in fact received;

d. Group home providers' instructions for allowable costs are consistent in the use of personal care allowances; and

e. Group home providers' accounting practices are monitored so that accounts accurately reflect expenses incurred and are timely recorded and reconciled.

DHS RESPONSE

The DHS-CFO, with input from MRDDA, is in the process of establishing procedures to ensure safeguarding of customer funds. The procedures will incorporate functions outlined in Recommendation 5 (a-e) of the OIG Report. These procedures will provide detailed information and guidance for overseeing client bank accounts, to include bank accounts established on behalf of the customer by residential providers, and to ensure that customer funds are spent according to program requirements. The procedure will emphasize closer scrutiny by PCD staff of community accounts and provider bank records as well as expense records. In addition, PCD will request and examine the MRDDA clients' IFP to better understand the financial plans developed by case managers and to aid in the appropriate disbursement of these funds.

OIG COMMENT

The actions taken and planned by DHS should correct the conditions noted.

FINDINGS AND RECOMMENDATIONS

FINDING 6: PROVIDER AGREEMENTS FOR INTERMEDIATE CARE FACILITIES

SYNOPSIS

MAA did not timely execute Medicaid provider agreements, which were used to obtain services for clients placed in ICFMRs, and executed agreements that contained outdated or otherwise incorrect references to the CFR. Also, MAA improperly extended these provider agreements beyond the expiration dates and continued to use these agreements to obtain services for the clients. We attribute these conditions to DOH's insufficient legal review of provider agreements and the failure to adequately and timely address continuing problems. These expired agreements could affect the District's ability to obtain Medicaid funds. Additionally, MAA's use of expired agreements and improperly extending agreements may jeopardize the health and safety of the clients. Inappropriate CFR citations loosen controls that protect the rights of the District and the clients.

AUDIT RESULTS

As a part of our audit, we examined 47 provider agreements that were executed between the period October 1, 1998, and December 30, 1999. We found that 21 agreements had expired before the execution of a new agreement. MAA has the authority to extend a provider agreement for up to 2 months, if it receives written notice from the Health Regulatory Administration (HRA) before expiration of the original agreement.

While each of these agreements were eventually renewed, we noted that MAA extended the agreement period for 21 providers beyond 2 months from the original expiration date specified in the agreement. In several cases, we noted that services were provided for as much as 5 months after the agreements had expired. According to MAA, new agreements were not issued timely because HRA failed to certify the group home providers' facilities. However, documentation showed that HRA certified the group home providers' facilities prior to the expiration date of the agreements.

We also noted that existing agreements contained incorrect references to CFR citations. Specifically, the sections referenced in the agreements were in many cases no longer valid because of updates that were made to the applicable sections of the CFR. We brought this matter to the attention of an attorney advisor within the DOH, Office of General Counsel (OGC), during March 2000. This person advised us that a review of provider agreements was reinitiated after our inquiry. Inappropriate CFR citations weaken controls that protect the rights of the District and the clients.

FINDINGS AND RECOMMENDATIONS

We learned through discussions with staff of OGC and our document test that on December 16, 1999, and again on March 29, 2000, OGC requested MAA to provide copies of all Medicaid provider agreements for review. The purpose of OGC's review was to ensure that the agreements were current and in compliance with federal and District laws.

A legal sufficiency review of these agreements has not been completed. Staff of the OGC told us that all of the documents requested were not provided and that this lack of cooperation by MAA staff hindered their efforts to completely review the agreements. OGC informed us that a preliminary review of several agreements provided by MAA showed incorrect citations and discrepancies between similar agreements.

RECOMMENDATION 6

We recommend that the Director of DOH:

a. Update provider agreements to conform with current CFR sections;

b. Consider revisions to provider agreements, where needed, to ensure that they can be used to justify breaches or identify noncompliance with any of the agreement provisions;

b. Ensure that provider agreements are renewed soon after they expire in accordance with 42 CFR § 442.16, and that extension times pending their certification of a provider are kept to a minimum;

c. Establish formal procedures for reviewing provider agreements for legal sufficiency; and

d. Bring to the attention of your staff the need to cooperate on projects of this nature.

DHS RESPONSE

DOH agrees that the ICF/MR provider agreements that were submitted for legal sufficiency review contained errors in some of the legal citations. The standard ICFMR provider agreement has now been reviewed by DOH's Office of General Counsel (OGC) and a new draft provider agreement has been forwarded to MAA.

As to the recommendation that the provider agreements be modified to include contractual enforcement provisions, this recommendation can be more efficiently implemented through execution of contracts between MRDDA and the group home providers. The provider agreement is intended to document the obligations of the provider to comply with the more general conditions of participation in the Medicaid program. The District is implementing a person-centered approach to care delivery, which provides greater specificity in terms of care management by the providers. The details of the new care management initiative are not

necessarily mandated by specific federal standards. For the new District of Columbia mandated care management goals, which go beyond the requirements of federal law, enforcement options must be created through the enactment of legislation, rule making or contracting. Again, the goal is to have a mechanism in place for ensuring that the lCFMR group homes comply with MRDDA's new policies and procedures. While the provider agreement addresses the conditions of Medicaid participation, more detailed care management issues will be more appropriately addressed through civil infraction sanctions and contract remedies.

As to contract remedies, MRDDA will work with various agencies, including the Office of Contracting and Procurement (OCP), in assessing the viability of having contracts with the ICF/MR group home providers. The District will review these enforcement strategies in determining how best to create incentives for the ICF/MRs to comply with the new standards and policies that the District is now establishing for the care of MRDDA customers.

OIG COMMENT

The actions taken and planned by DOH should adequately address conditions noted. However, DOH may want to consider facilitating coordination between OCP and MAA in order to ensure that the provider agreements incorporate the protective language found in the contracts for appropriated funds so that there is consistent language throughout the contracting process.

FINDINGS AND RECOMMENDATIONS

FINDING 7: HEALTH CERTIFICATES, TRANSPORTATION, TAXES, AND HABILITATION PLANS

SYNOPSIS

Group home providers did not ensure that employees received required annual health examinations, and did not maintain required transportation records that accounted for movement of client. Further, group home providers did not file and pay required taxes timely. Records show that requirements of official IHPs we examined were generally fulfilled. However, group home providers did not always have records to support compliance with requirements. Providers lacked oversight procedures that would ensure that its employees obtained health certificates timely and properly and accurately completed transportation logs. DOH lacked controls that would preclude executing agreements with providers who have not timely filed District tax returns for various taxes that they owe. DHS had controls that would preclude awarding contracts to such delinquent providers, but lacked controls that would preclude exercising contract option years for such providers. Consequently, the health and safety of clients were at risk and DOH and DHS have the potential for improperly executing agreements and contract option years to providers who owe the District taxes.

AUDIT RESULTS

Health Certificates Not Obtained. As part of our audit, we reviewed personnel records for 40 direct care staff employed at 4 group homes to determine whether required physical examinations were performed prior to employment and updated annually thereafter. The review disclosed that 18 employees were hired without obtaining health certificates prior to employment and 8 certificates were not updated annually. Health certificates certify that the employee is free from communicable diseases (see table below). Group home residents can be exposed to unnecessary health risk when certificates are not obtained prior to employment and updated annually. We believe this condition is due to insufficient oversight and monitoring by DHS and/or DOH.

Group Home	Employee Records Examined	Employees Without Health Certificate Prior to Employment	Employees Without Current Health Certificate
A	12	7	2
B	11	5	2
C	10	6	0
D	7	0	4
Totals	40	18	8

FINDINGS AND RECOMMENDATIONS

DCMR, Title 22, § 3509.6 state that "[e]ach employee, prior to employment and annually thereafter, shall provide a physician's certification that a health inventory has been performed and that the employee's health status would allow him or her to perform the required duties." Further, Section 3509.7 states that "[a] new employee's physical examination shall have been performed within ninety days prior to employment."

Transportation Logs Not Properly Maintained. We found that most of the group home providers are not complying with an October 29, 1999, policy directive entitled "Standards of Care and Procedures for Transportation of Persons with Developmental Disabilities," issued by the DHS. This directive requires providers to maintain transportation logs whenever group home residents are being transported to day care and other destinations. We noted that the transportation log was not being used to record departure and arrival times to fully account for residents' time while being transported to obtain needed services. We also noted that required signatures by the receiving authority accounting for the presence of each resident were frequently omitted. In our opinion, group home providers do not properly maintain the logs due to insufficient management oversight and a general lack of regard for the directive. The proper use of transportation logs should help providers to timely detect hazardous conditions for clients and establish individual accountability.

Additionally, group home personnel informed us that there have been numerous occasions where clients were either late leaving for day care programs or late coming home without an adequate explanation. We believe that group home providers should report tardiness issues that are caused by contractors who provide transportation to the pertinent District government agency or official.

D.C. Taxes Not On File. Our review of records maintained by the Office of Tax and Revenue (OTR) disclosed that 11 of the 26 group home providers were not in compliance with the District's tax laws. The provider either had not filed tax returns or had not paid the taxes due. As of May 2000, the estimated amount of delinquent taxes totaled approximately $320,000. D.C. Code, Title 47, § 1812.7 (a)(1) states, "the total amount of taxes due as shown on the taxpayer's return is due and payable in full at the time prescribed in this subchapter for the filing of such return…."

Additionally, tax verifications were requested and performed for 13 (all CRF providers) of the 26 group home providers. DCMR, Title 27 § 2204.7 contains tax regulations which provide that, before making an affirmative determination of responsibility for any contract exceeding $100,000, the contracting officer must obtain certification from the OTR that the prospective contractor has complied with D.C. tax laws and regulations. We noted that the tax verification showed that one group home provider was not in compliance with District tax laws.

The remaining 13 group home providers did not have a request for tax verification because they were all ICFMR group home providers. Provider agreements for ICFMRs do not

require a tax verification. In our opinion, ICFMR provider agreements should be revised to include this requirement.

Individual Habilitation Plans. The audit included a review of Individual Habilitation Plans (IHPs) for 55 clients residing at 10 different group homes to determine whether services were provided for the clients as outlined in their respective IHPs. Our review of supporting records showed that services were provided as outlined. However, we noted several instances where clients did not receive services on the date required. In those instances, we were informed by staff of the provider that the client resisted having an examination performed (for example, a dental examination) on that particular date.

Specifically, we were able to review supporting documents for the services outlined in the IHP for all 55 of the clients selected for review. However, we did not assess the quality of those services provided. The following is a list of typical services described in an IHP for ICFMR clients:

- Annual Physical Examination
- Nursing Assessment
- Audiology (hearing examination)
- Dental Examination
- Ophthalmology (eye examination)
- Psychiatric Review
- Nutritional Evaluation
- Social Work Assessment
- Psychological Evaluation
- Behavior Treatment Plan
- Occupational Therapy Assessment
- Physical Therapy Evaluation
- Speech/Language Evaluation
- Recreational Therapy Assessment
- Individual Plan of Care Program (day program plan)
- Individual Financial Plan

These services varied from individual to individual depending on the client's current medical condition. For instance, some individuals may have been required to visit a physical therapist annually or every 6 months due to their physical condition, while others were recommended to see a physical therapist every 3 years.

During the course of the audit, a matter was brought to our attention by the U.S. Justice Department which involved an allegation of abuse or neglect to one of the clients that was selected in our sample. The allegations included the contention that certain medical services were not provided to a client when needed. However, our review of that client's IHP and

FINDINGS AND RECOMMENDATIONS

medical records indicated, based upon supporting records, that the client had received his required annual assessments and had received periodic follow-up treatment as recommended.

RECOMMENDATION 7

We recommend that the Director of DHS and DOH, coordinate activities to:

a. Ensure that required physical examinations are performed prior to employment and updated annually thereafter for all direct care staff;

b. Notify group home providers of the requirement to maintain and complete transportation logs that account for the whereabouts of clients' locations;

c. Assess the satisfaction of group home providers who use transportation services from District contractors as to the timeliness of their services and other related transportation issues that may expose clients to unnecessary risks;

d. Ensure that services described in a client IHP are provided on the date required;

e. Execute agreements with providers only if they are in compliance with District of Columbia tax laws;

f. Revise the provider agreements to meet the requirements of the DCMR to ensure consistency in the application of tax regulations for all group home providers.

DHS RESPONSE

In its response, DHS stated that to require pre-employment physical examinations may be in violation of Title VII of the Civil Rights Act of 1964, the Americans with Disabilities Act, and the Rehabilitation Act. Therefore, to ensure compliance with statutes regarding pre and post employment health screenings, DHS stated that they would submit the regulations cited by the OIG (DCMR Title 22 Sections 3509.6 and 3509.7) to the Office of Human Rights for and EEO assessment and guidance regarding this issue. Additionally, MRDDA plans to conduct satisfaction surveys of group home providers regarding experiences with contracted transportation. The survey will be conduct through the Provider Coalition. DHS and DOH will collaborate with the CFO to address the issue of entering into agreements with providers who are in compliance with the tax laws of the District.

OIG COMMENT

The action taken or planned by DHS should correct the conditions noted.

FINDINGS AND RECOMMENDATIONS

FINDING 8: PAYMENTS TO GROUP HOME PROVIDERS

SYNOPSIS

The audit disclosed that procedures used by DHS to process monthly payments to ICFMR group home providers are inadequate. Our review of the payment process revealed significant weaknesses over four interrelated functions involved in processing monthly payments to ICFMRs. These functions are: (1) client processing to determine benefits; (2) the receipt and maintenance of client funds; (3) the review and approval of ICFMR invoices; and (4) the disbursement of payments to ICFMR group home providers.

We found that thousands of dollars in monthly Medicaid payments that DHS made to ICFMRs were not accurate. The payments were not accurate because most ICFMR billing invoices did not reflect the correct amount of patient (client) liability, which is used in the computation of the cost of care amount due to the ICFMR group home providers. As a result of this inaccuracy, the DHS improperly retained Medicaid funds that instead should be used to offset the cost of care for many clients. We also found that the District of Columbia is not the representative payee for all clients. Consequently, the District may be paying more for the cost of care for some clients than it should. There is no legal requirement for the District government to be the representative payee for all clients in its care.

The lack of adequate procedures is mainly attributed to DHS not establishing written procedures and other controls over payment processing. We also noted a lack of an integrated system of communication and information sharing between operating managers at DOH, DHS, and the private contractor that processes Medicaid payments for the District. Written procedures and an integrated system of communication sharing is needed to process payments and related documents in an accurate and timely manner because the responsibility for these functions rests within different divisions and administrations of DOH and DHS, and also with the private contractor.

AUDIT RESULTS

We reviewed supporting documentation for approximately $6 million in monthly payments to 10 ICFMRs and 2 CRF group home providers. We also reviewed relevant payment policies and procedures developed by MAA. We held discussions with officials of DOH, DHS, and a private contractor retained by the District to perform various functions involved in processing Medicaid payments. The discussions were held to obtain relevant information for four functions involved in processing monthly payments to ICFMRs.

FINDINGS AND RECOMMENDATIONS

Processing Client Benefits

DHS, MRDDA, Client Intake Division. Functions include determining eligibility for client benefits (i.e., Social Security, SSI, Veterans), processing necessary forms, and annually re-certifying client eligibility for benefits. We noted that no formal procedures had been established for these functions. We also noted that no requirement to establish the District of Columbia as the representative payee for all clients in the care of MRDDA had been established. Consequently, the benefits of some clients are received by someone other than the District Government and were not available by the District to offset the cost of care for that client. During our review, we found several instances of this.

We requested from the SSA client benefits information for 141 clients in the care of MRDDA in an effort to determine the number of clients receiving benefits by someone other than the District Government. SSA did not provide us this information, stating that the information was confidential and could only be used in an investigation (as opposed to an audit). Therefore, we could not determine the number of clients who receive benefits (that are not used to offset the cost of care) and thus could not determine the amount of funds lost by the District.

DHS Income Maintenance Administration Special Services Division. Client benefits information is forwarded to this division from the MRDDA Client Intake Division. Functions of this division include processing, coding, and updating client benefits information (such as Social Security or SSI entitlement amounts) into a computerized database called the Medicaid Management Information System (MMIS). This division codes client information in the MMIS, which authorizes monthly payments to ICFMRs.

We noted that increases in client benefits were processed but not always updated on the providers' billing invoice (called a turnaround document). Increases in client benefits that are not reflected on billing invoices ultimately results in an inaccurate monthly payment to ICFMR providers. We noted that no written procedures had been established over this function.

Receiving and Maintaining Funds

DHS, Office of the CFO, Payments and Collections Division. Functions include receiving and maintaining client benefits, forwarding monthly Medicaid payments to ICFMR providers, and forwarding quarterly personal allowance payments to clients. We noted that DHS maintained excess funds that should be applied against the clients' cost of care in order to reduce the amount of the Medicaid payment. The excess funds were the result of increases in client benefits that are not reflected on the ICFMR billing invoice. Since DHS was not billed accurately, the excess was not remitted to the ICFMR providers. DHS officials contend that ICFMR providers were paid based upon the remittance advice (the amount billed).

FINDINGS AND RECOMMENDATIONS

Increases in client benefits were processed but not always reflected on the billing invoices, which created the excess funds that were maintained by DHS. These excess funds should be used to reduce the Medicaid payment for the clients' cost of care. DHS officials are aware of this situation; however, they could not provide our office with the total amount of the excess funds maintained for the current or previous fiscal years.

Reviewing and Approving Invoices

DHS, MRDDA, Contracts Division. Contract administration functions include the review of invoices for payments for clients who reside in CRF group homes. We noted that no written procedures had been established for functions involved in contract administration. During our review of payments, we identified payments to a group home provider for clients that were not authorized for placement in the group home. As a result, the District incurred additional costs. We were also informed by staff of this division that supporting documentation for some payments made during fiscal year 1999 could not be located.

DOH, Medical Assistance Administration. Functions include maintenance of ICFMR providers monthly billing invoices. Although this unit maintains the billing invoices, the invoices are not reviewed for accuracy. In fact, no District employee reviews ICFMR billing invoices for accuracy prior to payment. This lack of review takes on an added significance considering that a prepayment review of the invoices would detect incorrect patient (client liability) amounts.

Furthermore, we noted that most ICFMR providers did not record the clients' hospital stays on the billing invoice, although they are required to do so. A reduction to an ICFMR group home provider's monthly payment is made for clients who stay in a hospital for more than 18 days during a fiscal year. MAA did not review the billing invoices, although MAA can obtain detailed information to verify the number of days a client has stayed in a hospital. As a result, the District may be paying more for the cost of care for clients than it should.

Disbursing of Payments to Providers

DHS, Office of the CFO, Payments and Collections Division. Medicaid payments are forwarded monthly to ICFMRs to offset the clients' cost of care. However, the clients' personal allowance, currently $70 per month, and the clients' portion of the cost of care (called patient liability) is forwarded to ICFMR providers on a quarterly basis. Staff of the group home providers informed us that this delay creates financial hardships for the client as well as for the provider. DHS officials could not adequately explain why these payments were made only on a quarterly basis (this condition is discussed in more detail in Finding 5). We noted that no written procedures had been established for the function of disbursing payments to group home providers.

FINDINGS AND RECOMMENDATIONS

RECOMMENDATION 8

We recommend that the Director of DHS and DOH coordinate activities to establish written policies and procedures for the functions of processing client benefits, receiving and maintaining client funds, reviewing and approving ICFMR provider invoices, and disbursing payments to providers.

DHS RESPONSE

The DHS-CFO is currently in the process of establishing written procedures and other controls for the processing of Cost-of-Care payments to ICF/MR providers. In addition, the DHS-CFO- PCD has began to establish communication and information links with various operating management units, and administrations in an effort to help facilitate timely and effective payments to group home providers. The OCFO supports an integrated system of communication sharing to include written procedures regarding the processing of payments to ICF/MR's. In collaboration with the DHS-CFO, MRDDA will develop a process to require eligible customers in ICF/MR's to contribute toward their cost of care.

OIG COMMENT

The actions planned by DHS meet the intent of the recommendation.

FINDINGS AND RECOMMENDATIONS

FINDING 9: CLIENT ACCOUNT TAX WITHHOLDING

SYNOPSIS

Tax returns had not been filed for clients who had monies withheld from their savings accounts for taxes on the interest that they earned. Since monies had been withheld from these accounts for several years and because the statute of limitations for claiming refunds for monies withheld is limited to 3 years, tax returns for these clients for tax year 1996 had to be filed with the Internal Revenue Service (IRS) by April 15, 2000. The IRS may not legally be able to return the amounts withheld for taxes from the clients' interest bearing accounts should returns be filed after the deadline for tax year 1996. MRDDA had no procedures in place to adequately monitor client accounts to ensure that withholding for taxes was appropriate or that tax returns were filed when in the best interest of the client. Consequently, taxes withheld unnecessarily from client accounts since 1992 have not been returned to the client, and the client had lost interest income on the amounts unnecessarily withheld.

AUDIT RESULTS

Preliminary examinations of client accounts showed that a Maryland financial institution had been sending Forms 1099-DIV (Dividends and Other Distributions) to the DHS that disclosed the interest paid to the client and amounts that have been withheld and forwarded to the IRS. The financial institution had withheld a total of $414.72 for tax year 1999 from the accounts of six clients based on a review of 181 Form 1099s made available for our review. Prior year Form 1099s have been requested from DHS, but not received.

Our interviews with case managers and representatives of the CFO indicated that tax returns were not generally prepared to obtain refunds in prior years. We did not determine why tax withholding started, but tax withholding started in or prior to tax year 1992. Tax withholding may be due to some prior unsatisfied tax liability or from failing to provide the financial institution with appropriate tax information.

We also noted that periodic statements of the financial institution did not account for tax withholding; in fact, the statement transactions did not account for the resulting statement balance. The dividend transactions, if fully added to the account by reinvestment, should be added to reach the ending balance. However, the ending balance was lower, which apparently was attributable to the taxes withheld. A brief interview with a representative of the financial institution attributed this condition to a software deficiency, of which they had not been aware. Nonetheless, the Form 1099 did notify the District of taxes withheld.

FINDINGS AND RECOMMENDATIONS

DHS needs to determine the reasons tax is withheld and initiate action to stop the financial institution from withholding taxes on clients' accounts (unless justified by law) so that the clients do not continue to lose interest on unnecessary tax withdrawals and associated compounding income.

The agency should also explore whether the Internal Revenue Service Restructuring and Reform Acts of 1997 and 1998 permit the suspension of the statute of limitations on filing refund claims during periods of disability for clients. If the suspension applies, then the clients would benefit from filing for tax withheld at least as far back as 1992 instead of limiting refunds to the tax years 1996 through 1999.

CURRENT STATUS

This finding was originally presented to management in a MAR dated March 27, 2000 (Exhibit 5). In the MAR, we recommended that DHS file tax returns for tax year 1996 by midnight April 17, 2000. Subsequently, we discovered that for tax year 1996, tax returns had to be in the hands of the IRS no later than April 15, 2000. Management's actions on the recommendations in the MAR meet the intent of the recommendations and should correct the conditions noted.

RECOMMENDATION 9

We recommend that the Director, DHS:

a. File tax returns in time to obtain refunds for tax year 1996;

b. Provide financial assistance to MRDDA to manage the financial affairs of its clients;

c. Determine why monies are withheld for taxes and, if appropriate, initiate action to stop tax withholding by the Maryland financial institution; and

d. Explore whether the Restructuring and Reform Acts of 1997 and 1998 would permit the District to obtain refunds for tax years prior to 1996.

DHS RESPONSE

Tax returns for the six MRDDA clients mentioned in the OIG report were filed on April 15, 2000. In addition, tax return checks (from the IRS) for tax year 1996 were received by PCD on behalf of these clients. The DHS-CFO is committed to continue providing financial assistance to MRDDA, and to maintain and file tax returns for MRDDA clients when appropriate.

FINDINGS AND RECOMMENDATIONS

OIG COMMENT

The actions taken or planned meet the intent of the recommendations.

FINDINGS AND RECOMMENDATIONS

FINDING 10: CLIENT WORK PROGRAMS

SYNOPSIS

Improvement to controls are needed for client work programs to ensure that mentally retarded persons, a vulnerable population, are not exploited and are paid for work performed or are otherwise engaged in meaningful care or training while participating in work programs. The audit disclosed no written procedures or other controls that would require and ensure appropriate monitoring of clients while participating in work programs. Neither DOH nor DHS monitored client work programs sufficiently to ensure that clients are treated fairly and compensated in an equitable manner. The MRDDA caseworkers were required to conduct only three quarterly visits to each group home and only one annual visit to each day treatment facility. As a result, we consider the potential for clients to be exploited to be a high-risk area.

AUDIT RESULTS

Client work programs are recommended and often included in a client's IHP, which includes the individual program plan of care (IPP). Work program services are provided to clients by various day treatment vendors. The types of work performed by clients range from sorting letters to janitorial work, depending on the client's developmental needs and their ability. The work and training programs are designed to provide physical and vocational therapy and training, as well as additional income for the clients.

Based upon discussions with the staff of group home providers and our examination of payroll and related records, we found there were no written procedures or other controls for client work programs. In addition, neither DOH nor DHS adequately monitored client work programs to ensure that clients were treated fairly and compensated in an equitable manner. Without written procedures and other controls to ensure that clients are treated fairly and equitably, clients may be exploited. The MRDDA caseworkers were required to conduct only three quarterly visits to the group home and only one annual visit to the day treatment facility.

We held discussions with staff of group home providers and examined the clients' payroll earning statements, work schedules, and other related documents in client files at group homes to obtain general information on client work programs. Our review of earning statements for several clients disclosed inconsistencies in the amount of pay received by clients. We noted, for example, that the amount of pay received by one client for a 2-week work period was $6.74 and for another 2-week period the client was paid $110.23. This matter was discussed with the staff of the group home; however, no adequate explanation was given. In fact, the provider's staff expressed a concern over the inconsistent amounts of pay received by the clients. We were further informed that MRDDA caseworkers did not routinely monitor client work programs and

FINDINGS AND RECOMMENDATIONS

only review client earning statements quarterly during group home site visits. An example of inconsistent amounts of pay received by a specific client is shown below:

Pay Period	Check Amount
5/19/00	$ 6.74
6/02/00	$ 75.85
6/15/00	$ .00
7/31/00	$ 16.86
8/11/00	$110.23

The group home further informed us that the client in the example reported to and remained at the day treatment facility for about the same number of hours each pay period. When we questioned as to why the pay amounts varied on any given day, staff at the group home stated that work may not be available on certain days. We find this explanation to be inadequate in view of the client's vulnerability and with no explanation for what the client was doing during those periods in which he was supposedly in a work program.

Group home providers did not monitor activities at client day programs to ensure that work programs described in clients' individual program plans are being implemented. The staff of several group home providers told us that day program contractors have agreements/contracts with the District (and not with the group home providers) and, therefore, believe that MRDDA caseworkers or other District officials should monitor activities over client work programs.

RECOMMENDATION 10

We recommend that the Director, DHS and DOH, coordinate activities to:

a. Establish written procedures for client work programs that helps to ensure that clients are properly compensated and obtain the benefits intended by work programs; and

b. Determine and establish authority and responsibility for continuous monitoring of client work programs.

DHS RESPONSE

While the MRDDA case manager monitors all customer services, monitoring of work activity programs is conducted by assigned staff in the MRDDA Day Program Resources Branch. Staff from this branch conduct scheduled and unscheduled visits to day program sites to coordinate and oversee the delivery of day program services. However, the staff in the Day Program Resources Branch has dwindled down to three, while the numbers of customers to be served remains at over 1,400. Consequently, the level of monitoring necessary to ensure quality customer service has declined.

FINDINGS AND RECOMMENDATIONS

As part of the restructuring efforts, MRDDA will revisit existing procedures for client work/work activity programs and MRDDA's monitoring and quality assurance roles and responsibilities, as they pertain to day and work activity programs.

OIG COMMENT

The DHS response satisfies the recommendation.

E X H I B I T S

Exhibit 1

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HUMAN SERVICES

DIRECTOR

October 20, 2000

Charles C. Maddox, Esq.
Inspector General
Office of the Inspector General
717 14th Street, N.W.,
Washington, D.C. 20005

Dear Mr. Maddox:

Enclosed is the response prepared by the Department of Human Services (DHS) and the Department of Health (DOH), to the draft report (OIG No. 23-99JA) of the Office of Inspector General's (OIG) audit of the Mental Retardation and Developmental Disabilities Program (MRDDP). The audit cited ten (10) findings of factors that appeared to contribute to less than desirable conditions within the MRDDP system such as insufficient policies and procedures, noncompliance with directives, lack of management continuity, etc.

The audit provided recommendations that were centered around best practices management improvements, and ensuring compliance with existing statutes and regulations. In some instances, a few of the recommendations raised potential problems with federal and District civil rights statutes (e.g., pre-employment medical screening, and the use of arrest records in making employment decisions). DOH and DHS are in agreement with the majority of the recommendations and the systematic improvements they were designed to produce. The responses contained herein reflect a significant degree of sustained systematic changes that have been made or are in the process of being implemented.

DHS and DOH express appreciation for the work of the OIG in evaluating the services provided by MRDDP, the opportunity to respond to the audit and the extension of time the OIG provided for this response.

I would be delighted to have an opportunity for you to meet with me and the managers at DOH and DHS to discuss further your recommendations and our response to your audit report.

Sincerely,

Carolyn N. Graham
Deputy Mayor for Children

Enclosures

cc: William J. DiVello

FINDING 1: STRATEGIC PLANNING AND PERFORMANCE MEASUREMENT

Abbreviated Synopsis: MRDDA did not implement a strategic plan and did not establish a performance measurement system. Consequently, MRDDA could not definitively measure or evaluate program progress, efficiency, and effectiveness, although it spent more than $438 million from fiscal year 1995 through 1999.

Recommendation 1: Director of DHS, implement a strategic plan for MRDDA regardless of management turnover that incorporates a performance measurement system to help ensure that measurable goals and objectives are met and to commit management to specific improvements.

Actions Planned/Taken:

Under the direction of Deputy Mayor, Carolyn N. Graham, who also serves as the Interim Director of DHS, a strategy to implement an extensive restructuring of the entire Mental Retardation and Developmental Disabilities (MRDD) system has been forged. Since January, 2000, significant changes have been implemented to bring stability, efficiency and effectiveness to the MRDD system. This process has been aided by the establishment of an Inter-Agency Task Force that is responsible for implementing those tasks and procedures that facilitate the restructuring.

Strategic goals include development of Policies and Procedures for MRDDA and other agencies in the MRDD system; Outsourcing Case Management Services for MRDDA; implementation of a plan to Exit the Evans Consent Decree; Conducting Assessments on Customers at-Risk for Critical Health Outcomes; Establishment of a MRDD Fatality Review Committee; and Development and Submission of Revised Medicaid Waiver Application. Time frames and performance measures have been developed for each of these goals.

The goal of implementing and complying with the draft 2000 Plan for the Conclusion of Evans v. Williams, also referred to as the Evans Exit Plan, has superceded implementing the MRDDA 5-Year Strategic Plan. The Evans Exit Plan was drafted in response to the court's order to develop a plan to conclude the Evans v. Williams court case. However, goals delineated in the existing MRDDA 5-Year Strategic Plan continue to be relevant to MRDDA's overarching mission of administering a network of services that support persons with mental retardation and other developmental disabilities, and MRDDA has made significant strides in implementing various tasks that support the goals. The goal to effect system change to enhance service delivery and make it customer driven is being accomplished through the person-centered planning approach to customer service. The goal to enhance federal and other revenue maximization efforts is currently being addressed through obtaining and funding customer supports with the implementation of the Home and Community-Based Medicaid Waiver. The development of a MRDDA Customer Information System meets the goal of implementing an automated management information system, and the enhancement of a quality assurance program is in progress.

DHS/MRDDA must revisit the specific tasks in the MRDDA 5-Year Plan to ensure that they are in line with the tasks and mandates of the Evans Exit Plan, the MRDDA realignment plan, and the MRDD system philosophical model change.

Responsible Agency: DHS

Target Completion Dates: Target dates for completion of various tasks are found in the draft 2000 Plan for the Conclusion of Evans v. Williams. Target dates for completion of draft Policies and Procedures range from August 2000 to December 2000, which include critical policies regarding incident management and transportation that are already completed. The target date for implementing the Outsourcing of Case Management is February/March 2001. The goals of Conducting Assessments on Customers at-Risk for Critical Health Outcomes; Establishment of a MRDD Fatality Review Committee; and Development and Submission of Revised Medicaid Waiver Application were all completed between July 2000 and October 2000.

FINDING 2: RECOVERY OF DISALLOWED COSTS

Abbreviated Synopsis: MAA did not recover $6.8 million in overpayments to 8 group home provide during the 6 year period, from fiscal year 1991 to 1996. This amount has been outstanding since 1997. As a result of not recovering this amount, the District has lost a least $300,000 in interest revenue.

Recommendation 2: Director of DOH reevaluate the current method used to recover overpayments from group home providers and take sufficient measure, in compliance with federal regulations to collect outstanding amount due to the District

Actions Planned/Taken: The law requires the Medicaid Program, which in the District of Columbia is operated by the Medical Assistance Administration (MAA), to reimburse the federal government within 60 days. The financial reporting unit files HCFA Form 64 reconciling payments due to the federal government, thereby complying with the law. MAA then informed the providers, when it issued the settlement agreement, Notice of Program Reimbursement (NPR), that 20% will be taken from their monthly payroll to recoup the overpayment. The 20% monthly recoupment percentage is generally the standard percentage used for this program.

The Intermediate Care Facilities/Mentally Retarded (ICFs/MR) are small provider operations that consist of group homes with 6-8 beds. The providers are currently struggling with the financial burden on their ongoing operations from the 20% monthly recoupment. If the Medicaid Program used a more aggressive approach to recoup overpayments, such a strategy would create a potential severe financial drain ~~harm to~~ on the funds the providers maintain for their operations, and more than likely put some of them out of business. The closure of group homes because of financial problems arising from an acceleration of the repayment agreements for the $6.8M in overpayment already in place is even more likely because the providers have probably included the 20% monthly recoupment in their current budgets. Moreover, it is not clear whether or not the District could legally accelerate the rate of recoupment for the providers who were overpaid by $6.8M since these providers and the District have already agreed on the repayment plan. In any event, the District of Columbia would be faced with an impossible task of trying to find homes for its MRDDA customers should any of the group homes close because of financial difficulties. Therefore, when MAA reviews the overall situation it seeks to recoup an amount that would allow recovery of the overpayment to the provider but permit the facilities to remain in operation. DOH, however, will continue to work with the providers with regard to any future overpayments to determine whether the rate of recovery can be set at a higher monthly rate.

Responsible Agency: DOH

Target Completion Dates: In progress as an ongoing task.

FINDING 3: EMPLOYMENT OF DIRECT CARE WORKERS

Abbreviated Synopsis: Direct care workers employed by operators of group homes for the mentally retarded have histories of criminal convictions and arrests. Direct care workers with histories of criminal convictions and arrests were hired or allowed to continue to work for group home providers because providers did not always initiate required background investigations. Consequently, the clients' safety and financial interest may have been exposed to unnecessary risk.

Recommendation 3: Director of DHS in conjunction with the Director of DOH:

a. Consider recommending to the Council of the District of Columbia that D.C. Law 12238, Unlicensed Personnel Criminal Background Check, be amended to include appropriate language that required evaluation of an applicant's arrest record in determining his/her suitability as a direct care worker:

b. Draft the implementing regulation so as to require periodic updates of criminal history checks:

c. Take appropriate action against group home providers, as you deem necessary, with respect to the employment status of individuals who have criminal histories: and

d. Draft legislation that would require employees of providers to report arrests and convictions within 30 days and that providers take action appropriate for the circumstances.

Actions Planned/Taken:

Status of Regulations/Finalizing Requirement for Nationwide Criminal Background Check of Care Staff

The "Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998" became effective on April 20, 1999. Therefore, under current law, all health care facilities licensed by the District of Columbia and/or participating in the D.C. Medicaid Program must obtain nationwide criminal background checks of all unlicensed personnel who are applicants for employment or contract services, and these facilities may not employ or contract with any unlicensed person who has been convicted of an offense enumerated in the statute or who has been placed on the Nurse Aide Abuse Registry.

The implementing regulations were promulgated by the Director of the Department of Health as proposed rulemaking on June 16, 2000. They can be found at 47 D.C. Reg. 5179 et seq. The public comment period has been extended through the end of October. If no substantive changes are mandated as a result of the public comments, the regulations can be published as final shortly thereafter. If there are substantive changes to be made, the revised regulations would have to be issued as proposed, and another public comment period would take place. This would delay publication of the final regulations into calendar year 2001.

Arrest Records of Applicants

The Department of Health has carefully considered the recommendation that the law and implementing regulations be amended to include language that requires an evaluation of an applicant's arrest record by a provider in determining his or her suitability as a direct care worker. The recommendation raises numerous public policy concerns. Because of concerns with the possibility of false accusations, racial profiling, the due process rights of an accused person (the person has not yet been convicted of a crime), and the U.S. EEOC Guidelines for the Uniform Selection of Employees which may actually prohibit reliance on arrests records in making certain employment decisions, the District may not be able to implement this specific recommendation. The District will reexamine this issue, after consultation with the U.S. Attorney, Office of Corporation Counsel, the D.C. Human Rights Office and the U.S. Equal Employment Opportunity Commission (EEOC), after the current regulations have been in effect for a sufficient period of time to assess the legality of and need, if any, for any further amendments.

Periodic Updates of Background Checks

The Department of Health has also carefully considered the recommendation that the regulations be drafted to include a requirement that health-care facilities obtain updated criminal background checks on each unlicensed employee or contract worker at certain specified intervals. Our research indicates that, of the states that have enacted criminal background check requirements, only 12.5% have enacted periodic update requirements, and we note that neither Maryland nor Virginia require periodic updates. We do not believe that it would be practical or cost-effective to impose this requirement at this time; due to the high rate of staff turnover in this field. We conclude that it is more likely that a direct care worker will seek employment in a different facility, and therefore be required to undergo a new initial check, than that he or she will remain employed by a facility long enough to trigger a periodic update.

Actions against Providers

The Department of Health is, as has been recommended, monitoring providers to ensure that criminal background checks are being conducted. We currently assess and prosecute, as warranted, civil infractions and licensure and certification actions against providers covered by existing law and regulations that mandate background checks (Medicaid facilities). We note that there are several such cases currently pending before the Office of Adjudication and Hearings. As soon as the final implementing regulations are promulgated, we will expand these actions to include all types of health care facilities licensed by the District of Columbia and/or participating in the D.C. Medicaid Program.

Responsible Agency: DOH

Target Completion Dates: In progress as an ongoing task.

FINDING 4: DIRECT CARE STAFF TRAINING

Abbreviated Synopsis: The audit disclosed that some of the direct care staff employed by group home providers had not completed required training in accordance with District and federal regulations. As a result, the protection, safety, and care of the clients may be jeopardized.

Recommendation 4: Directors, DHS and DOH, coordinate activities to:

a. Provide group home providers with the guidance needed to uniformly implement the requirements outlined in the DCMR. The guidance should include procedures to:

1. require prior approval of training courses;
2. identify course requiring competency based training: and
3. identify training courses that must be completed prior to allowing direct care staff to work with clients and the time frames other courses must be completed.

b. Require group home providers to develop and maintain a record system that would allow monitoring and tracking of individual staff training accomplishments.

c. Require group home providers to perform routine and periodic assessments of staff training to determine training needs.

Actions Planned/Taken: The District proposes to put a system in place to ensure that all employees assigned to residential and day treatment programs attend orientation and preliminary skill-training prior to assignment to a work site. An assessment of training needs will be conducted to determine the specific training to be implemented, in order to meet acceptable standards required in DCMR.

However, as a preliminary step, and in order to develop basic skills and competencies in staff of at-risk community providers, MRDDA developed and implemented an emergency short-term training program for those staff. Training occurred on May 23, 2000, July 12, 2000, August 17, 2000 and September 12, 2000, which involved approximately 273 Direct Care Staff, Qualified Mental Retardation Professionals, and Medical Support Staff from 12 provider organizations. Topics of training included Best Practices, Incident Management, Health Services and Advocacy, and Consumer Awareness.

An on-going training program for all staff working within the mental retardation and developmental disabilities services (MRDD) system will be developed and implemented. As part of its restructuring efforts, MRDDA will employ a Training Coordinator to interface with its employees and providers. The agency will establish general training guidelines that will provide guidance for determining the frequency of required refresher training and advanced training for provider staff. Guidelines will also include requirements for periodic assessments of staff training needs.

Group home providers are to maintain training records, training attendance sign-in sheets, and training curriculum that they develop, to allow for tracking of individual staff training accomplishments.

Responsible Agency: DHS

Target Completion Dates:

Planning Phase	-	October 2000 - December 2000
Implementation Phase	-	January 2001 - Ongoing

FINDING 5: CLIENT BANK ACCOUNTS

Abbreviated Synopsis: The audit disclosed that clients' bank accounts were not properly accounted for or adequately safeguarded against loss. We found that group home providers did not always place client funds in interest bearing accounts, as required.

Recommendation 5: Director, DHS, establish procedures to ensure that:

a. Group home providers place client funds in interest bearing accounts;
b. PCD forward personal allowance payments to group home providers for deposit to client account in a timely manner;
c. Group home providers' independently verify that items purchased for clients were in fact received;
d. Group home providers' instructions for allowable costs are consistent in the use of personal care allowances; and
e. Group home providers' accounting practices are monitored so that accounts accurately reflect expenses incurred and are timely recorded and reconciled.

Actions Planned/ Taken: The DHS-CFO, with input from MRDDA, is in the process of establishing procedures to ensure safeguarding of customer funds. The procedures will incorporate functions outlined in Recommendation 5 (a-e) of the OIG Report. These procedures will provide detailed information and guidance for overseeing client bank accounts, to include bank accounts established on behalf of the customer by residential providers, and to ensure that customer funds are spent according to program requirements.

The procedure will emphasize closer scrutiny by PCD staff of community accounts and provider bank records as well as expense records. In addition, PCD will request and examine the MRDDA clients' IFP to better understand the financial plans develop by case managers and to aid in the appropriate disbursement of these funds.

Responsible Agency: DHS

Target Completion Dates: The target completion date for the policies and procedure manual is scheduled for mid-November, 2000.

FINDING 6: PROVIDER AGREEMENTS FOR INTERMEDIATE CARE FACILITIES

Abbreviated Synopsis: MAA did not timely execute Medicaid agreements, which were used to obtain services for clients placed in ICFMRs, and executed agreements that contained outdated or other wise incorrect reference to the CFR.

Recommendations 6: Recommended that the Director of DOH:

a. Update provider agreements to conform with current CFR sections;
b. Consider revisions to provider agreements, where needed, to ensure that they can be used to justify breaches or identify noncompliance with any of the agreement provisions;
c. Ensure that provider agreements are renewed soon after they expire in accordance with 42 CFR $442.16, and that extension times pending their certification of a provider are kept to a minimum;
d. Establish formal procedures for reviewing provider agreements for legal sufficiency; and
e. Bring to the attention of your staff the need to cooperate on projects of this nature.

Actions Planned/Taken:

(a) Update of Provider Agreements to Conform with current CRF sections

DOH agrees that the ICF/MR provider agreements that were submitted for legal sufficiency review contained errors in some of the legal citations. The standard ICFMR provider agreement has now been reviewed by DOH's Office of General Counsel (OGC) and a new draft provider agreement has been forwarded to MAA. A copy of the proposed draft provider agreement is attached as Exhibit A.

(b) Use of Provider Agreements to Enforce Contractual Breaches

As to the recommendation that the provider agreements be modified to include contractual enforcement provisions, this recommendation can be more efficiently implemented through execution of contracts between MRDDA and the group home providers. The provider agreement is intended to document the obligations of the provider to comply with the more general conditions of participation in the Medicaid program. The District is implementing a person centered approach to care delivery which provides greater specificity in terms of care management by the providers. The details of the new care management initiative are not necessarily mandated by specific federal standards. For the new District of Columbia mandated care management goals, which go beyond the requirements of federal law, enforcement options must be created through the enactment of legislation, rule-making or contracting. Again, the goal is to have a mechanism in place for ensuring that the ICFMR group homes comply with MRDDA's new policies and procedures. While the provider agreement addresses the conditions of

Medicaid participation, more detailed care management issues will be more appropriately addressed through civil infraction sanctions and contract remedies.

As to contract remedies, MRDDA will work with various agencies, including the Office of Contracting and Procurement (OCP), in assessing the viability of having contracts with the ICF/MR group home providers. The District will review these enforcement strategies in determining how best to create incentives for the ICF/MRs to comply with the new standards and policies that the District is now establishing for the care of MRDDA customers.

(c) Timely Renewal of Provider Agreements:

DOH concurs with the OIG's assessment that MAA has not been able to renew many of the provider agreements for ICFs/MR prior to the expiration of the group home provider agreements. In accordance with the federal rules, MAA may extend the provider agreement for a single period up to two months beyond the original expiration date, if it receives written notice from DOH's Health Regulation Administration (HRA), the state survey agency, before the expiration date of the agreement, that the extension will not jeopardize the patient's health and safety. DOH has determined that for public policy reasons (including the potential harm to clients in immediately removing the client from a facility whenever HRA is unable to timely complete its survey process form renewing the provider agreement) it will not terminate the provider agreement while the survey investigative process is being completed. MAA, MRDDA and HRA, however, will continue to coordinate their review of facilities to ensure that when there is a delay in a provider agreement being renewed that the delay does not expose MRDDA customers to conditions that jeopardize the customer's physical safety and well being.

Federal financial participation (FFP) generally ends on the effective date of termination of the provider agreement, or if not terminated, on the expiration date of the provider agreement. However, FFP is available after the effective date of termination or expiration of the provider agreement, for a period not to exceed 120 days if the Medicaid Agency takes action to terminate or not renew the provider agreement, and the termination and non-renewal action is based on HRA's certification that there is no jeopardy to resident's health and safety.

A survey of the provider agreements by Office of General Counsel (OGC) of information provided by HRA and MAA indicates that on a monthly basis the provider agreements for at least 20 ICFs/MR had expired beyond the two-month extension period. Several meetings and consultations with HRA and MAA staff have been conducted by OGC to ascertain the basis for this problem. OGC has concluded that the delays in renewal of the provider agreements occur primarily because HRA, which conducts the inspections of the facilities for MAA, has not been able to timely complete its inspection of a facility to determine whether the facility meets all of the conditions of federal participation, and therefore, is entitled to renewal of the provider agreement. This conclusion is based on a review of the timelines for the expiration of the provider agreements, the 60-day extension period, the applicable federal regulations, the dates of the survey inspections,

and the assessment of the length of time for the investigators to prepare the survey reports. Again, MAA relies upon the survey inspection by HRA in determining whether a provider agreement can be renewed. The delay in HRA completing the survey inspection process is largely attributable to staffing shortages. This is particularly the case given the heightened oversight of the program in the recent year arising from broad media coverage of MRDDA care issues, increased monitoring by HCFA of HRA's inspections, development of new initiatives by a task force of District agencies assessing care delivery to MRDDA customers, and a substantial increase in oversight responsibilities for HRA in monitoring other health facilities and programs.

According to HRA, the process for determining whether an ICFMR provider agreement should be renewed starts months before the initial expiration date of the provider agreement. An HRA investigator is required to visit the facility during this period and to conduct a survey using the survey guidelines mandated by the U.S. Department of Health and Human Services (DHHS) Health Care Finance Administration (HCFA). Only staff trained and certified by HCFA can be utilized for these surveys. Because of staffing limitations and increased work load, the survey inspection for renewal of the provider agreement does not always occur early enough to allow the inspection process (including the correction of any deficiencies) to be completed before the expiration of the provider agreement. Moreover, when deficiencies are noted in the survey inspection, HRA then must determine whether the deficiencies violate any condition of federal participation. If the deficiencies violate a condition of federal participation, but do not involve jeopardy to the MRDDA client's physical safety and health, HRA issues a notice advising the facility of the deficiencies and allowing the facility 90 days to correct the deficiencies. However, if the violations do involve potential jeopardy to the client's physical safety, HRA issues a notice mandating corrective action within 23 days. All of these notices are sent to both MAA and MRDDA. The two time periods (90 or 23 days) are determined by the applicable federal regulations.

During the 90 day or 23 day time period, HRA will not recommend to MAA that the provider agreement be renewed. MAA, in turn, will begin the process of terminating a facility's eligibility to participate in the Medicaid program. If the deficiencies remain uncorrected at the expiration of the applicable time period, the facility will be disqualified by MAA from further participation in Medicaid program. The provider may appeal the termination or non-renewal action. However, filing an appeal does not toll the termination or non-renewal action. MRDDA will remove customers from a facility that has been disqualified from further participation in the Medicaid program.

Given the cumbersomeness of the foregoing process for renewing provider agreements, DOH is attempting to address the staffing needs at HRA to ensure that the HCFA mandated survey inspections can be completed early enough to permit the provider to correct deficiencies which would otherwise prevent renewal of the provider agreement before its expiration (or at least within the 60 day grace period following the agreement's stated expiration date). HRA is in the process of hiring an additional four (4) investigators and one (1) nurse to handle the survey inspections for the MRDDA program. DOH will also work with MRDDA to ensure that if there is a delay in renewing

a provider agreement for a facility, that there is no jeopardy to the physical safety and well-being of the MRDDA customers at the facility.

(d) Establishment of Formal Procedure for Review of Provider Agreements

MAA is continuing to review the draft provider agreement and is expected to begin using the new provider agreement in the near future. OGC plans on reviewing the standard ICFMR provider agreement annually for appropriate updating.

(e) Direction to DOH staff to Cooperate on Projects

DOH agrees that staff must cooperate with efforts to ensure that provider agreements are timely renewed and investigations of any DOH operations that may be conducted by external investigative bodies or various programs within DOH, including the Office of General Counsel.

Responsible Agency: DOH

Target Completion Dates: Tasks are ongoing

FINDING 7: HEALTH CERTIFICATES, TRANSPORTATION, TAXES, AND HABILITATION PLANS

Abbreviated Synopsis: Group home providers did not ensure that employees received required annual health examinations, and did not maintain required transportation records that accounted for movement of client. Further, group home providers did not file and pay required taxes timely. Consequently, the health and safety of clients were at risk and DOH and DHS have the potential for improperly executing agreements and contract option years to providers who owe the District taxes.

Recommendation 7: Director of DHS and DOH, coordinate activities to:

a. Ensure that required physical examinations are performed prior employment and Updated annually thereafter for all direct care staff;
b. Notify group home providers of the requirement to maintain and complete transportation logs that account for the whereabouts of clients' locations
c. Assess the satisfaction of group home providers who used transportation services from District contactors as to the timeliness of their services and other related transportation issues that may expose clients to unnecessary risks;
d. Ensure that services described in a client IHP are provided on the date required;
e. Execute agreements with providers only if they are in compliance with District of Columbia tax laws;
f. Revise the provider agreements to meet the requirements of the DCMR to ensure consistency in the application of tax regulations for all group home provider.

Actions Planned/Taken: To require pre-employment physical examinations may be in violation of Title VII of the Civil Rights Act of 1964, the Americans with Disabilities Act, and the Rehabilitation Act. Therefore, to ensure compliance with statutes regarding pre and post employment health screenings, DHS this we will submit the regulations cited by the OIG (DCMR Title 22 Sections 3509.6 and 3509.7) to the Office of Human Rights for and EEO assessment and guidance regarding this issue.

The transportation policy dated October 29, 1999, as referenced in the OIG Report, contains instructions regarding utilization of transportation logs. While provider staff received training on the October 29, 1999 policy in the months of January and February of 2000, apparently provider employees are not consistently adhering to the policy. DOH and DHS have developed a revised transportation policy which not only includes protocols pertaining to use of transportation logs, referred to as the Daily Transportation Transfer Form, but addresses training of provider staff who are involved in transportation. Initial training on the use of the Daily Transportation Transfer Form is scheduled to be completed by MRDDA, by November 30, 2000. Also, training on the transportation policy, is to occur before Drivers or Attendants/Driver's Aides begin to

assume his/her responsibilities. Further, the policy mandates that the provider comply with any periodic refresher training courses that may be provided by MRDDA.

MRDDA plans to conduct satisfaction survey's of group home providers regarding experiences with contracted transportation. The survey will be conduct through the Provider Coalition.

DHS and DOH will collaborate with the CFO to address the issue of entering into agreements with providers who are in compliance with the tax laws of the District.

Responsible Agency: DHS

Target Completion Dates: Completion of training on the use of the Daily Transportation Transfer Form is scheduled to be completed by MRDDA, by November 30, 2000.

FINDING 8: PAYMENTS TO GROUP HOME PROVIDERS

Abbreviated Synopsis: Procedures used by DHS to process monthly payments to ICFMR group home providers are inadequate.

Recommendation 8: We recommend that the Director of DHS and DOH coordinate activities to establish written policies and procedures for the functions of processing client benefits, receiving and maintaining client funds, reviewing and approving ICF/MR provider invoices, and disbursing payments to providers.

Actions Planned/Taken:

The DHS Office of the Chief Financial Officer (OCFO-Payments and Collections Division (PCD) is responsible for receiving and maintaining client benefits, and making payments to ICF-MR providers (Medicaid providers) for the client Cost-of-Care. The four interrelated functions involved in processing payments to ICF/MR's are performed by various units within the DOH and DHS. (1) Client processing to determine benefits is performed by MRDDA and IMA Office of Long Term Care; (2) The receipt and disbursement of payments to ICF/MR's is conducted by the OCFO-PCD; (3) The review and approval of ICF/MR invoices is conducted by the DC Medicaid Office.

The DHS-CFO is currently in the process of establishing written procedures and other controls for the processing of Cost-of-Care payments to ICF/MR providers. In addition, the DHS-CFO-PCD has began to establish communication and information links with various operating management units, and administrations in an effort to help facilitate timely and effective payments to group home providers. The OCFO supports an integrated system of communication sharing to include written procedures regarding the processing of payments to ICF/MR's.

In collaboration with the DHS-CFO, MRDDA will develop a process to require eligible customers in ICF/MR's to contribute toward their cost of care.

Responsible Agency: DHS

Target Completion Dates: Complete draft of procedures for requiring customers in ICF/MR's to contribute toward their cost of care by February 2001.

FINDING 9: CLIENT ACCOUNT TAX WITHHOLDING

Abbreviated Synopsis: Tax returns had not been filed for clients who had monies withheld from their savings accounts for taxes on the interest that they earned. Taxes withheld unnecessarily from client account since 1992 have not been returned to the client, and the client had lost interest income on the amount unnecessarily withheld.

Recommendation 9: It is recommended that the Director, DHS:

a. Files tax returns in time to obtain refunds for tax year 1996.
b. Provider financial assistance to MRDDA to manage the financial affairs of its clients:
c. Determine why monies are withheld for taxes and, if appropriate, initiate action to stop tax withholding by the Maryland financial institutions: and
d. Explore whether the Restructuring and Reform Acts of 1997 and 1998 would permit the District to obtain refunds for tax years prior to 1996.

Actions Planned/Taken:

a. Tax returns for the six (6) MRDDA clients mentioned in the OIG report were filed on April 15, 2000. In addition, tax return checks (from the IRS) for tax year 1996 were received by PCD on behalf of these clients.

b. The DHS-CFO is committed to continue providing financial assistance to MRDDA, and to maintain and file tax returns for MRDDA clients when appropriate.

c. Based on information from Rushmore Bank, monies were withheld "**because of a notified payee under reporting.**" According to past practices, tax returns were prepared and filed on behalf of MRDDA clients by residential providers. Bank statements to include Form 1099 DIV., were not accessible to residential providers and therefore created the instances of under reported dividends.

The DHS-CFO has corrected this deficiency by taking responsibility for filing all applicable client tax returns.

d. The Restructuring and Reform Act of 1998 extends the normal statue of limitation for income tax refunds for periods of disability before, on, or after the date of enactment of the Act, (which was on July 22, 1998).

When determining how far back the Act covers, it must be determined 1) Whether an income tax return has or has not already been filed for the years in question, and 2) Which years were within the statue of limitation.

Assuming all MRDDA clients were "financially disabled" as defined by the Act, prior to and since enactment of the Act, then the Act would allow refunds going back to tax years 1995 and in some cases 1994. For the reasons stated, it is our opinion that income tax

return was previously filed. The DHS-OCFO-PCD is in the process of filing returns for all applicable clients as recommended.

Responsible Agency: DHS-CFO

Target Completion Dates: Ongoing Tasks

FINDING 10: CLIENT WORK PROGRAMS

Abbreviated Synopsis: Improvement to controls are needed for clients work programs to ensure that mentally retarded persons, a vulnerable population, are not exploited and are paid for work performed or are otherwise engaged in meaningful care or training while participating in work programs.

Recommendation 10: Director, DHS and DOH, coordinate activities to:

a. Establish written procedures for client work programs that help to ensure that clients are properly compensated and obtain the benefits intended by work programs; and
b. Determine and establish authority and responsibility for continuous monitoring of client work programs.

Actions Planned/Taken: The OIG Report references client work programs, which are also referred to as work activities. The objectives of work activity programs are to refine personal and work adjustment skills and to prepare customers for work opportunities. Work activities are conducted in a structured work center that has vocational activities such as mail services, clerical, arts and crafts, and horticulture. Customers are paid according to their rate of production, which is a major reason why compensation amounts vary.

While the MRDDA case manager monitors all customer services, monitoring of work activity programs is conducted by assigned staff in the MRDDA Day Program Resources Branch. Staff from this branch conduct scheduled and unscheduled visits to day program sites to coordinate and oversee the delivery of day program services. However, the staff in the Day Program Resources Branch has dwindled down to three, while the number of customers to be served remains at over 1,400. Consequently, the level of monitoring necessary to ensure quality customer service has declined.

As part of the restructuring efforts, MRDDA will revisit existing procedures for client work/work activity programs and MRDDA's monitoring and quality assurance roles and responsibilities, as they pertain to day and work activity programs.

Responsible Agency: DHS

Target Completion Dates: January 2001.

OFFICE OF THE INSPECTOR GENERAL
Audit of the Mental Retardation and Developmental Disabilities Program
Audit No. 23-99JA

Schedule of Interest Calculations

Fiscal Year	Outstanding Amounts	Annualized Interest Rates	Amount of Interest Revenue Lost
FY 1991	$ 11,320	0.068	$ 770
FY 1992	$ 791,010	0.046	$ 36,386
FY 1993	$ 1,492,859	0.0315	$ 47,025
FY 1994	$ 1,023,371	0.0377	$ 38,581
FY 1995	$ 2,185,210	0.0563	$ 123,027
FY 1996	$ 999,500	0.0534	$ 53,373
Subtotal	$ 6,503,270		$ 299,163
FY 1997	Note 1	-	$ -
FY 1998	Note 1	-	$ -
FY 1999	Note 1	-	$ -
FY 2000	$ 6,690,719	-	$ -
Total			$ 299,153

NOTE 1: Information was not provided to determine outstanding amounts for FY 1997, 1998, and 1999.